SERFF Tracking Number:	*LFCR-125715451*	*State:*	*Arkansas*
Filing Company:	*Massachusetts Mutual Life Insurance Company*	*State Tracking Number:*	*39506*
Company Tracking Number:	*MMN-PRT-AR*		
TOI:	*LTC03I Individual Long Term Care*	*Sub-TOI:*	*LTC03I.001 Qualified*
Product Name:	*SignatureCare*		
Project Name/Number:	*/*		

Filing at a Glance

Company: Massachusetts Mutual Life Insurance Company

Product Name: SignatureCare	SERFF Tr Num: LFCR-125715451	State: ArkansasLH
TOI: LTC03I Individual Long Term Care	SERFF Status: Closed	State Tr Num: 39506
Sub-TOI: LTC03I.001 Qualified	Co Tr Num: MMN-PRT-AR	State Status: Approved-Closed
Filing Type: Form	Co Status:	Reviewer(s): Harris Shearer
	Authors: Smith Darlene, Trudy Weigel	Disposition Date: 07/21/2008
	Date Submitted: 07/02/2008	Disposition Status: Approved-Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name:	Status of Filing in Domicile: Authorized
Project Number:	Date Approved in Domicile:
Requested Filing Mode:	Domicile Status Comments: Authorized
Explanation for Combination/Other:	Market Type: Individual
Submission Type: New Submission	Group Market Size:
Overall Rate Impact:	Group Market Type:
Filing Status Changed: 07/21/2008	
State Status Changed: 07/21/2008	Deemer Date:

Corresponding Filing Tracking Number:

Filing Description:

Please see cover letter.

Company and Contact

Filing Contact Information

(This filing was made by a third party - LCA01)

SERFF Tracking Number:	*LFCR-125715451*	*State:*	*Arkansas*
Filing Company:	*Massachusetts Mutual Life Insurance Company*	*State Tracking Number:*	*39506*
Company Tracking Number:	*MMN-PRT-AR*		
TOI:	*LTC03I Individual Long Term Care*	*Sub-TOI:*	*LTC03I.001 Qualified*
Product Name:	*SignatureCare*		
Project Name/Number:	*/*		

Trudy Weigel, Compliance Analyst 2
P.O. Box 4243
Woodland Hills, CA 91365-4243

trudy.weigel@lifecareassurance.com
(818) 867-2240 [Phone]
(818) 867-2508[FAX]

Filing Company Information

Massachusetts Mutual Life Insurance Company	CoCode: 65935	State of Domicile: Massachusetts
Long Term Care Administrative Office	Group Code: 435	Company Type:
P.O. Box 4243		
Woodland Hills, CA 91365-4243	Group Name:	State ID Number:
(818) 867-2450 ext. [Phone]	FEIN Number: 04-1590850	

SERFF Tracking Number:	*LFCR-125715451*	*State:*	*Arkansas*
Filing Company:	*Massachusetts Mutual Life Insurance Company*	*State Tracking Number:*	*39506*
Company Tracking Number:	*MMN-PRT-AR*		
TOI:	*LTC03I Individual Long Term Care*	*Sub-TOI:*	*LTC03I.001 Qualified*
Product Name:	*SignatureCare*		
Project Name/Number:	*/*		

Filing Fees

Fee Required?	Yes
Fee Amount:	$75.00
Retaliatory?	Yes
Fee Explanation:	State of Domicile, Massachusetts, charges $75 per filing.
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Massachusetts Mutual Life Insurance Company	$75.00	07/02/2008	21210757

SERFF Tracking Number:	*LFCR-125715451*	*State:*	*Arkansas*
Filing Company:	*Massachusetts Mutual Life Insurance Company*	*State Tracking Number:*	*39506*
Company Tracking Number:	*MMN-PRT-AR*		
TOI:	*LTC03I Individual Long Term Care*	*Sub-TOI:*	*LTC03I.001 Qualified*
Product Name:	*SignatureCare*		
Project Name/Number:	*/*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor (FM)	07/21/2008	07/21/2008

Amendments

Item	Schedule	Created By	Created On	Date Submitted
Cover Letter	Supporting Document	Trudy Weigel	07/21/2008	07/21/2008

SERFF Tracking Number:	*LFCR-125715451*	*State:*	*Arkansas*
Filing Company:	*Massachusetts Mutual Life Insurance Company*	*State Tracking Number:*	*39506*
Company Tracking Number:	*MMN-PRT-AR*		
TOI:	*LTC03I Individual Long Term Care*	*Sub-TOI:*	*LTC03I.001 Qualified*
Product Name:	*SignatureCare*		
Project Name/Number:	*/*		

Disposition

Disposition Date: 07/21/2008
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*LFCR-125715451*	*State:*	*Arkansas*
Filing Company:	*Massachusetts Mutual Life Insurance Company*	*State Tracking Number:*	*39506*
Company Tracking Number:	*MMN-PRT-AR*		
TOI:	*LTC03I Individual Long Term Care*	*Sub-TOI:*	*LTC03I.001 Qualified*
Product Name:	*SignatureCare*		
Project Name/Number:	*/*		

Item Type	Item Name	Item Status	Public Access
Supporting Document	Certification/Notice	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	Yes
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Supporting Document	Cover Sheet	Approved-Closed	Yes
Supporting Document *(revised)*	Cover Letter	Approved-Closed	Yes
Supporting Document	Cover Letter	Withdrawn	Yes
Form	Contingent Benefit Upon Lapse Endorsement	Approved-Closed	Yes
Form	Potential Rate Increase Disclosure Form	Approved-Closed	Yes
Form	Reduction of Benefits Endorsement	Approved-Closed	Yes
Form	Things You Should Know Before You Buy Long Term Care Insurance	Approved-Closed	Yes
Form	Important Consumer Information Regarding the Arkansas Long-Term Care Insurance Partnership Program	Approved-Closed	Yes
Form	Important Notice Regarding Your Policy's Long-Term Care Insurance Partnership Status	Approved-Closed	Yes
Form	Outline of Coverage	Approved-Closed	Yes
Form	Outline of Coverage	Approved-Closed	Yes
Form	Application for Long Term Care Insurance Policy	Approved-Closed	Yes
Form	Application for Long Term Care Insurance Policy	Approved-Closed	Yes

SERFF Tracking Number:	*LFCR-125715451*	*State:*	*Arkansas*
Filing Company:	*Massachusetts Mutual Life Insurance Company*	*State Tracking Number:*	*39506*
Company Tracking Number:	*MMN-PRT-AR*		
TOI:	*LTC03I Individual Long Term Care*	*Sub-TOI:*	*LTC03I.001 Qualified*
Product Name:	*SignatureCare*		
Project Name/Number:	*/*		

Amendment Letter

Amendment Date:

Submitted Date: 07/21/2008

Comments:

Pursuant to my conversation this morning with Rosalind Minor, the original letter submitted is deleted and replaced with the corrected letter with today's date below.

Thank you for your assistance.

Changed Items:

Supporting Document Schedule Item Changes:

User Added -Name: Cover Letter

Comment:

AR MM Corected filing letter 07-21-08.pdf

SERFF Tracking Number:	*LFCR-125715451*	*State:*	*Arkansas*
Filing Company:	*Massachusetts Mutual Life Insurance Company*	*State Tracking Number:*	*39506*
Company Tracking Number:	*MMN-PRT-AR*		
TOI:	*LTC03I Individual Long Term Care*	*Sub-TOI:*	*LTC03I.001 Qualified*
Product Name:	*SignatureCare*		
Project Name/Number:	*/*		

Form Schedule

Lead Form Number: MME-CNFLP1

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed	MME-CNFLP1	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Contingent Benefit Upon Lapse Endorsement	Initial			MME-CNFLP1.pdf
Approved-Closed	MM-N-PRI-LP	Other	Potential Rate Increase Disclosure Form	Initial			MM-N-PRI-LP.pdf
Approved-Closed	MME-RED1	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Reduction of Benefits Endorsement	Initial			MME-RED1.pdf
Approved-Closed	MM-N-LTC	Other	Things You Should Know Before You Buy Long Term Care Insurance	Initial			MM-N-LTC.pdf
Approved-Closed	MMN-PRT-AR	Other	Important Consumer Information Regarding the Arkansas Long-Term Care Insurance Partnership Program	Initial			MMN-PRT-AR.pdf
Approved-	MMD-PRT-	Other	Important Notice	Initial			MMD-PRT-

SERFF Tracking Number:	*LFCR-125715451*		*State:*	*Arkansas*		
Filing Company:	*Massachusetts Mutual Life Insurance Company*		*State Tracking Number:*	*39506*		
Company Tracking Number:	*MMN-PRT-AR*					
TOI:	*LTC03I Individual Long Term Care*		*Sub-TOI:*	*LTC03I.001 Qualified*		
Product Name:	*SignatureCare*					
Project Name/Number:	*/*					

Closed	AR		Regarding Your Policy's Long-Term Care Insurance Partnership Status			AR.pdf
Approved-Closed	MM500-OC-1-AR	Outline of Coverage	Outline of Coverage	Revised	Replaced Form #: MM500-OC-AR Previous Filing #: 36916	MM500-OC-1-AR.pdf
Approved-Closed	MM501-OC-1-AR	Outline of Coverage	Outline of Coverage	Revised	Replaced Form #: MM501-OC-AR Previous Filing #: 36916	MM501-OC-1-AR.pdf
Approved-Closed	MM500-A-1-AR	Application/ Enrollment Form	Application for Long Term Care Insurance Policy	Revised	Replaced Form #: MM500-A-AR Previous Filing #: 36916	MM500-A-1-AR.pdf
Approved-Closed	MM500-SA-1-1-AR	Application/ Enrollment Form	Application for Long Term Care Insurance Policy	Revised	Replaced Form #: MM500-SA-1-AR Previous Filing #: 36916	MM500-SA-1-1-AR.pdf

Massachusetts Mutual Life Insurance Company
Home Office: Springfield, MA 01111-0001
Long Term Care Administrative Office
P.O. Box 4243
Woodland Hills, CA 91365-4243
888.505.8952

Contingent Benefit Upon Lapse Endorsement
(Limited Premium Payment Policy)

This endorsement is attached to and made part of the Policy as of the Policy Effective Date.

Contingent Benefit Upon Lapse

If We:

(a) increase the premium rates under the Policy, which results in a cumulative increase of the annual premium equal to or exceeding the percentage of Your initial annual premium, as set forth in the table below; and

(b) the Policy lapses as described by the Premium Payment provisions of the Policy within one hundred twenty (120) days of the due date for the payment of the increased premium; and

(c) the ratio of the number of months You have already paid premium is forty percent (40%) or more than the number of months You originally agreed to pay; then

(d) the following options will become available under the Policy:

A. The Total Benefit Amount shown on the Policy Schedule page of the Policy may be reduced. This may be accomplished by either reduction of the Daily Benefit Amount or Benefit Period (subject to the availability of either one), to provide for a Total Benefit Amount that the current premium payable under the Policy will purchase. Reduction of the Total Benefit Amount will not be subject to evidence of insurability; or

B. The Policy may be converted to a paid-up status and the total lifetime Total Benefit Amount for Your reduced paid up Policy will be determined by multiplying 90% of the lifetime Total Benefit Amount, available at the time the Policy becomes paid-up, by the ratio of the number of months You have already paid premiums under the Policy, to the number of months You agreed to pay them at time of application. This option may be elected at any time during the one hundred twenty (120) day period referenced above. In addition, if the Policy lapses for non-payment of premium during this one hundred twenty (120) day period, this option will automatically be provided under the Policy.

The Daily Benefit Amount shown on the Policy Schedule page of the Policy will also be adjusted by the same ratio described above.

If You purchased a Policy with a lifetime Total Benefit Amount, only the Daily Benefit Amount shown on the Policy Schedule page of the Policy will be adjusted by the applicable ratio.

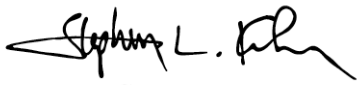
(over)

Your coverage is subject to the same Policy Benefit Provisions, Elimination Period, Limitations and Exclusions, and all other provisions of the Policy and riders that were in effect prior to Policy lapse, except an inflation protection rider, if any, attached to the Policy.

Triggers for a Substantial Premium Increase	
Issue Age	**Percent Increase Over Initial Premium**
Under 65	50%
65-80	30%
Over 80	10%

Signed for the Massachusetts Mutual Life Insurance Company at Springfield, Massachusetts.

President



Secretary

Massachusetts Mutual Life Insurance Company

Home Office: Springfield, MA 01111-0001
Long Term Care Administrative Office
P.O. Box 4243
Woodland Hills, CA 91365-4243
888.505.8952

Long Term Care Insurance Potential Rate Increase Disclosure Form

1. **Premium Rate:** The premium rate that is applicable to you and the coverage you have applied for is shown on the application.
2. **The premium for the Policy and any riders that are issued to you will be shown on the Policy Schedule of your Policy. This rate will be in effect unless and until the Company requests a premium rate increase and it is approved by the state in which your Policy was issued.**
3. **Rate Schedule Adjustments:**

   Premium rate or rate schedule adjustments will be effective on the next Policy Anniversary Date following the date the state approves a rate increase.
4. **Potential Rate Revisions:**

   This Policy is Guaranteed Renewable. This means that the rates for this product may be increased in the future. Your rates can NOT be increased due to your increasing age or declining health, but your rates may go up based on the experience of all policyholders with a Policy similar to yours.

   If you receive a premium rate or premium rate schedule increase in the future, you will be notified of the new premium amount and you will be able to exercise at least one of the following options:

   - Pay the increased premium and continue your Policy in force as is.
   - Reduce your Policy benefits to a level such that your premiums will not increase. (Subject to state law minimum standards.)
   - Exercise your nonforfeiture option if purchased. (This option is available for purchase for an additional premium.)
   - Exercise your contingent nonforfeiture option.* (This option may be available to you if you do not purchase a separate nonforfeiture option.)

***<u>Contingent Nonforfeiture</u>**

If the premium rate for your Policy goes up in the future and you didn't buy a nonforfeiture option you may be eligible for contingent nonforfeiture. Here's how to tell if you are eligible:

You will keep some long term care coverage, if:

- Your premium after the increase exceeds your original premium by the percentage shown (or more) in the following table; and
- You lapse (not pay more premiums) within 120 days of the increase.

The amount of coverage (i.e., new lifetime maximum benefit amount) you will keep will equal the total amount of premiums you've paid since your Policy was first issued. If you have already received benefits under the Policy, so that the remaining maximum benefit amount is less than the total amount of premiums you've paid, the amount of coverage will be that remaining amount.

Except for this reduced lifetime maximum benefit amount, all other Policy benefits will remain at the levels attained at the time of the lapse and will not increase thereafter.

Should you choose this Contingent Nonforfeiture option, your Policy, with this reduced maximum benefit amount will be considered "paid-up" with no further premiums due.

Turn the Page

Example:

- You bought the Policy at age 65 and paid the $1,000 annual premium for 10 years, so you have paid a total of $10,000 in premium.
- In the eleventh year, you receive a rate increase of 50%, or $500 for a new annual premium of $1,500, and you decide to lapse the Policy (not pay any more premiums).
- Your "paid-up" Policy benefits are $10,000 (provided you have at least $10,000 of benefits remaining under your Policy.)

Contingent Nonforfeiture **Cumulative Premium Increase Over Initial Premium That Qualifies for Contingent Nonforfeiture** (Percentage Increase is cumulative from the date of original issue. It does NOT represent a one-time increase)			
Issue Age	**Percent Increase Over Initial Premium**	**Issue Age**	**Percent Increase Over Initial Premium**
40-44	150%	71	38%
45-49	130%	72	36%
50-54	110%	73	34%
55-59	90%	74	32%
60	70%	75	30%
61	66%	76	28%
62	62%	77	26%
63	58%	78	24%
64	54%	79	22%
65	50%	80	20%
66	48%	81	19%
67	46%	82	18%
68	44%	83	17%
69	42%	84	16%
70	40%	85	15%

In addition to the contingent nonforfeiture benefits described above, the following reduced "paid-up" contingent nonforfeiture benefit is an option in all policies that have a fixed or limited premium payment period, even if you selected a nonforfeiture benefit when you bought your Policy. If both the reduced "paid-up" benefit AND the contingent benefit described above are triggered by the same rate increase, you can choose either of the two benefits.

You are eligible for the reduced "paid-up" contingent nonforfeiture benefit when all three conditions shown below are met:

1. The premium you are required to pay after the increase exceeds your original premium by the same percentage or more shown in the chart below;

Triggers for a Substantial Premium Increase	
Issue Age	**Percent Increase Over Initial Premium**
Under 65	50%
65-80	30%
Over 80	10%

2. You stop paying your premiums within 120 days of when the premium increase took effect; AND
3. The ratio of the number of months you already paid premiums is 40% or more than the number of months you originally agreed to pay.

If you exercise this option your coverage will be converted to reduced "paid-up" status. That means there will be no additional premiums required. Your benefits will change in the following ways:

a. The total lifetime amount of benefits your reduced "paid-up" Policy will provide can be determined by multiplying 90% of the lifetime benefit amount at the time the Policy becomes "paid-up" by the ratio of the number of months you already paid premiums to the number of months you agreed to pay them.

b. The daily benefit amounts you purchased will also be adjusted by the same ratio.

If you purchased lifetime benefits, only the daily benefit amounts you purchased will be adjusted by the applicable ratio.

Example:

- You bought the Policy at age 65 with an annual premium payable for 10 years.
- In the sixth year, you receive a rate increase of 35% and you decide to stop paying premiums.
- Because you have already paid 50% of your total premium payments and that is more than the 40% ratio, your "paid-up" Policy benefits are .45 (.90 times .50) times the total benefit amount that was in effect when you stopped paying your premiums. If you purchased inflation protection, it will not continue to apply to the benefits in the reduced "paid-up" Policy.

Massachusetts Mutual Life Insurance Company

Home Office: Springfield, MA 01111-0001
Long Term Care Administrative Office
P.O. Box 4243
Woodland Hills, CA 91365-4243
888.505.8952

Lowering Premiums by Reducing Benefits Endorsement

This endorsement is attached to and made part of the Policy as of the Policy Effective Date.

The following **Lowering Premiums by Reducing Benefits** provision is added to the Policy:

Lowering Premiums by Reducing Benefits

You have the option to reduce Your premiums under Your current coverage, subject to benefit availability, by selecting one of the following options:

- reducing the Total Benefit Amount shown on the Policy Schedule; or
- reducing the Daily Benefit Amount shown on the Policy Schedule.

The premium rate for Your reduced coverage will be based upon Your age on the date the Policy was originally issued and the premium rate in effect on the date the Total Benefit Amount or Daily Benefit Amount is reduced.

In the event the Policy is about to lapse due to nonpayment of premium, we will notify You of the options described above, which will become available to You in order to reduce Your coverage. This notice will be sent to You at least 30 days before the Policy is cancelled for nonpayment of premium.

Signed for the Massachusetts Mutual Life Insurance Company at Springfield, Massachusetts.

President

Secretary

Massachusetts Mutual Life Insurance Company

Home Office: Springfield, MA 01111-0001
Long Term Care Administrative Office
P.O. Box 4243
Woodland Hills, CA 91365-4243
888.505.8952

Things You Should Know Before You Buy Long-Term Care Insurance

Long-Term Care Insurance

- A long-term care insurance policy may pay most of the costs for your care in a nursing home. Many policies also pay for care at home or other community settings. Since policies can vary in coverage, you should read this policy and make sure you understand what it covers before you buy it.
- You should **not** buy this insurance policy unless you can afford to pay the premiums every year. Remember that the company can increase premiums in the future.
- The personal worksheet includes questions designed to help you and the company determine whether this policy is suitable for your needs.

Medicare

- Medicare does **not** pay for most long-term care.

Medicaid

- Medicaid will generally pay for long-term care if you have very little income and few assets. You probably should **not** buy this policy if you are now eligible for Medicaid.
- Many people become eligible for Medicaid after they have used up their own financial resources by paying for long-term care services.
- When Medicaid pays your spouse's nursing home bills, you are allowed to keep your house and furniture, a living allowance, and some of your joint assets.
- Your choice of long-term care services may be limited if you are receiving Medicaid. To learn more about Medicaid, contact your local or state Medicaid agency.

Shopper's Guide

- Make sure the insurance company or agent gives you a copy of a book called the National Association of Insurance Commissioners' "Shopper's Guide to Long-Term Care Insurance." Read it carefully. If you have decided to apply for long-term care insurance, you have the right to return the policy within 30 days and get back any premium you have paid if you are dissatisfied for any reason or choose not to purchase the policy.

Counseling

- Free counseling and additional information about long-term care insurance are available through your state's insurance counseling program. Contact your state insurance department or department on aging for more information about the senior health insurance counseling program in your state.

Facilities

- Some long-term care insurance contracts provide for benefit payments in certain facilities only if they are licensed or certified, such as in assisted living centers. However, not all states regulate these facilities in the same way. Also, many people move to a different state from where they purchased their long-term care insurance policy. Read the policy carefully to determine what types of facilities qualify for benefit payments, and to determine that payment for a covered service will be made if you move to a state that has a different licensing scheme for facilities than the one in which you purchased the policy.

Massachusetts Mutual Life Insurance Company

Home Office: Springfield, MA 01111-0001
Long Term Care Administrative Office
P.O. Box 4243
Woodland Hills, CA 91365-4243
888.505.8952

Important Consumer Information Regarding the Arkansas Long-Term Care Insurance Partnership Program

Some long-term care insurance policies sold in Arkansas may qualify for the Arkansas Long-Term Care Insurance Partnership Program (the Partnership Program). The Partnership Program is a partnership between state government and private insurance companies to assist individuals in planning their long-term care needs. Insurance companies voluntarily agree to participate in the Partnership Program by offering long-term care insurance coverage that meets certain State and Federal requirements. Long-term care insurance policies that qualify as Partnership Policies may protect the Insured's assets through a feature known as "Asset Disregard" under Arkansas Medicaid program.

Asset Disregard means that an amount of the Insured's assets equal to the amount of long-term care insurance benefits received under a qualified Partnership Policy will be disregarded for the purpose of determining the insured's eligibility for Medicaid. This generally allows a person to keep assets equal to the insurance benefits received under a qualified Partnership Policy without affecting the person's eligibility for Medicaid. All other Medicaid eligibility criteria will apply. Asset Disregard is not available under a long-term care insurance policy that is not a Partnership Policy. Therefore, You should consider whether Asset Disregard is important to You, and whether a Partnership Policy meets Your needs. ***The purchase of a Partnership Policy does not automatically qualify You for Medicaid.***

What are the Requirements for a Partnership Policy? In order for a policy to qualify as a Partnership Policy, it must, among other requirements:

- be issued to an individual after January 1, 2008;
- cover an individual who was an Arkansas resident when coverage first becomes effective under the policy;
- be a tax-qualified policy under Section 7702(B)(b) of the Internal Revenue Code of 1986;
- meet stringent consumer protection standards; and,
- must provide annual inflation protection for ages 75 and younger.

If You apply and are approved for long-term care insurance coverage, Massachusetts Mutual Life Insurance Company will provide You with written documentation as to whether Your Policy qualifies as a Partnership Policy.

What Could Disqualify a Policy as a Partnership Policy? Certain types of changes to a Partnership Policy could affect whether such policy continues to be a Partnership Policy. If You purchase a Partnership Policy and later decide to make any changes, You should first consult with Massachusetts Mutual Life Insurance Company to determine the effect of a proposed change. In addition, if You move to a state that does not maintain a Partnership Program or does not recognize Your Policy as a Partnership Policy, You would not receive beneficial treatment of Your Policy under the Medicaid program of that state. The information contained in this disclosure is based on current Arkansas and Federal laws. These laws may be subject to change. Any change in law could reduce or eliminate the beneficial treatment of Your Policy under Arkansas's Medicaid program.

Additional Information. If You have questions regarding long-term care insurance policies please contact Massachusetts Mutual Life Insurance Company. If You have questions regarding current laws governing Medicaid eligibility, You should contact the Arkansas Department of Human Services.

Massachusetts Mutual Life Insurance Company

Home Office: Springfield, MA 01111-0001
Long Term Care Administrative Office
P.O. Box 4243
Woodland Hills, CA 91365-4243
888.505.8952

Important Notice Regarding Your Policy's Long-Term Care Insurance Partnership Status

This disclosure notice is issued in conjunction with Your long-term care Policy:

Some long-term care insurance policies sold in Arkansas qualify for the Arkansas Long-Term Care Insurance Partnership Program. Insurance companies voluntarily agree to participate in the Partnership Program by offering long-term care insurance coverage that meets certain State and Federal requirements. Long-term care insurance policies that qualify as Partnership Policies may be entitled to special treatment, and in particular an "Asset Disregard," under Arkansas's Medicaid program.

Asset Disregard means that an amount of the Insured's assets equal to the amount of long-term care insurance benefits received under a qualified Partnership Policy will be disregarded for the purpose of determining the Insured's eligibility for Medicaid. This generally allows a person to keep assets equal to the insurance benefits received under a qualified Partnership Policy without affecting the person's eligibility for Medicaid. All other Medicaid eligibility criteria will apply. Asset Disregard is not available under a long-term care insurance policy that is not a Partnership Policy. **The purchase of a Partnership Policy does not automatically qualify You for Medicaid.**

Partnership Policy Status. **Your long-term care insurance Policy is intended to qualify as a Partnership Policy under the Arkansas Long-Term Care Partnership Program as of Your Policy's effective date.**

What Could Disqualify Your Policy as a Partnership Policy. If You make any changes to Your Policy, such changes could affect whether Your Policy continues to be a Partnership Policy. ***Before You make any changes, You should consult with Massachusetts Mutual Life Insurance Company to determine the effect of a proposed change.*** In addition, if You move to a State that does not maintain a Partnership Program or does not recognize Your Policy as a Partnership Policy, You would not receive beneficial treatment of Your Policy under the Medicaid program of that State. The information contained in this Notice is based on current State and Federal laws. These laws may be subject to change. Any change in law could reduce or eliminate the beneficial treatment of Your Policy under Arkansas's Medicaid program.

Additional Information. If You have questions regarding Your insurance Policy please contact Massachusetts Mutual Life Insurance Company. If You have questions regarding current laws governing Medicaid eligibility, You should contact the Arkansas Department of Human Services.

This form and all benefit statements received should be kept with Your Policy.

Massachusetts Mutual Life Insurance Company

Home Office: Springfield, MA 01111-0001
Long Term Care Administrative Office
P.O. Box 4243
Woodland Hills, CA 91365-4243
888.505.8952

Outline of Coverage for Long Term Care Insurance Policy Form MM500-P-AR

NOTICE TO BUYER: This Policy may not cover all of the costs associated with long term care incurred by the buyer during the period of coverage. The buyer is advised to review carefully all Policy limitations.

Caution: The issuance of this Long Term Care Insurance Policy is based upon the responses to the questions on the Application. A copy of the Application is enclosed. If the responses are incorrect or untrue, the Company may have the right to deny benefits or rescind the Policy. The best time to clear up any questions is now, before a claim arises! If, for any reason, any of the responses are incorrect, contact Us at the Long Term Care Administrative Office address shown above.

The Policy is an individual Policy of insurance.

PURPOSE OF OUTLINE OF COVERAGE

This outline of coverage provides a very brief description of the important features of the Policy. You should compare this outline of coverage to outlines of coverage for other policies available to You. This is not the insurance contract, but only a summary of coverage. Only the individual Policy contains governing contractual provisions. This means that the Policy sets forth in detail the rights and obligations of both You and the Company. Therefore, if You purchase this coverage, or any other coverage, it is important that You READ YOUR POLICY CAREFULLY!

FEDERAL TAX CONSEQUENCES

THE POLICY IS INTENDED TO BE A FEDERALLY TAX-QUALIFIED LONG TERM CARE INSURANCE CONTRACT AS DEFINED UNDER SECTION 7702B(b) OF THE INTERNAL REVENUE CODE OF 1986, as amended, and will be endorsed to conform to changes in that definition. You should consult with Your attorney, accountant, or tax advisor regarding the tax implications of purchasing this long term care insurance.

TERMS UNDER WHICH THE POLICY MAY BE CONTINUED IN FORCE OR DISCONTINUED

RENEWABILITY: THE POLICY IS GUARANTEED RENEWABLE. This means You have the right, subject to the terms of the Policy, to continue the Policy as long as You pay Your premiums on time. Massachusetts Mutual Life Insurance Company cannot change any of the terms of the Policy on its own, except that, in the future, IT MAY INCREASE THE PREMIUM YOU PAY.

Waiver of Premium

Premiums will not be due once We begin paying, and for as long as We continue to pay, benefits for Facility Services or Home and Community Based Services under the Policy. We will return any unearned premium to You on a pro-rata basis. Premium will again become due when We are no longer paying You because the Insured is no longer receiving Facility Services, or Home and Community Based Services at least once every week.

For an additional premium payment, an optional Waiver of Premium for Covered Partner Rider is also available, as described below.

TERMS UNDER WHICH THE COMPANY MAY CHANGE PREMIUMS

Premiums are subject to change. We can only change the premiums for the Policy if We change premiums, subject to the approval of the appropriate regulatory authority of the state in which this Policy was issued. We will give You at least sixty (60) days written notice at Your last address shown in Our records before We change Your premium.

TERMS UNDER WHICH THE POLICY MAY BE RETURNED AND PREMIUM REFUNDED

If You are not satisfied with the Policy, You may return it to Our agent or Us within thirty (30) days from the date You receive it. We will then refund any premium You have paid and the Policy, all riders and attachments will be considered never to have been in effect. Upon the death of the Insured, We will refund any unearned premium for the Policy on a pro-rata basis. We will make this refund within thirty (30) days of Our receipt of proof of the Insured's death. If You cancel the Policy after thirty (30) days, any unearned premium will be refunded to You on a pro-rata basis. If You purchase one of the optional Return of Premium Riders, upon the death of the Insured, all or a portion of the premiums paid for the Policy and riders will be returned to You, if other than the Insured, or Your Beneficiary.

THIS IS NOT MEDICARE SUPPLEMENT COVERAGE

If the Insured is eligible for Medicare, review the "Guide to Health Insurance for People with Medicare" available from Us. Neither Massachusetts Mutual Life Insurance Company nor its agents represent Medicare, the federal government or any state government.

LONG TERM CARE COVERAGE

Policies of this category are designed to provide coverage for one (1) or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, Maintenance or Personal Care Services, provided in a setting other than an acute care unit of a hospital, such as in a nursing home, in the community or in the home.

The Policy provides coverage for Qualified Long Term Care Services in the form of an expense incurred benefit for covered long term care expenses, subject to Policy Elimination Periods, Limitations and Exclusions described below.

BENEFITS PROVIDED BY THE POLICY

Covered Services

The Policy provides benefits for Qualified Long Term Care Services performed in a nursing facility or assisted living facility, and Maintenance or Personal Care Services performed in an assisted living facility and hospice care provided in a hospice facility. A Prescription Drug Benefit and Bed Reservation Benefit are available if Facility Services are being received in a nursing facility, assisted living facility or hospice facility. The Policy provides benefits for Home and Community Based Services, including home health care, adult day care and hospice care at home. Additional Policy benefits include those for Caregiver Training, an Emergency Response System, Ambulance Services and an Alternative Plan of Care.

Elimination Period

This is the number of days the Insured must receive either Facility Services or Home and Community Based Services, as defined in the Policy, pursuant to a Plan of Care, while the Policy is in force and the Insured is certified as being Chronically Ill, before We will begin paying benefits. An Elimination Period of thirty (30), sixty (60), ninety (90) or one hundred eighty (180) days may be chosen. For each day the Insured receives Facility Services or Home and Community Based Services, We will credit one (1) day toward satisfaction of the Elimination Period. These days do not need to be consecutive. Once the Insured has satisfied the Elimination Period, no future Elimination Period is required. Days may be accumulated under separate claims in order to satisfy the Elimination Period.

For an additional premium payment an Enhanced Elimination Period Rider is available, as described below.

Elimination Period for Coverage Outside of the United States

This is the number of days after the Insured has satisfied the Elimination Period previously described and receives either Facility Services or Home and Community Based Services Outside of the United States, as defined in the Policy, pursuant to a Plan of Care, while the Policy is in force and the Insured is certified as being Chronically Ill, before We will begin

paying benefits for coverage Outside of the United States. Days on which the Insured receives Facility Services or Home and Community Based Services Outside of the United States will first be used to satisfy the Elimination Period previously described. Once this Elimination Period has been satisfied, We will credit one (1) day towards satisfaction of the Elimination Period for Coverage Outside of the United States. This number of days will be equal to the number of days selected for the Elimination Period previously described. These days do not need to be consecutive; however, days will not be accumulated under separate claims in order to satisfy the Elimination Period for Coverage Outside of the United States. The Insured must first satisfy the Elimination Period before days will count towards satisfaction of the Elimination Period for Coverage Outside of the United States.

Total Benefit Amount

An unlimited Total Benefit Amount may be chosen for Lifetime coverage, or a lesser amount determined by multiplying the Daily Benefit Amount chosen by the Benefit Period selected - either 3,650 days (10 Years), 2,190 days (6 Years), 1,825 days (5 Years), 1,460 days (4 Years), 1,095 days (3 Years) or 730 days (2 Years). The result will be the Total Benefit Amount for all benefits payable under the Policy.

Daily Benefit Amount

The initial Daily Benefit Amount will be shown on the Policy Schedule page of the Policy. The current Daily Benefit Amount will be the initial Daily Benefit Amount adjusted to reflect the provisions of any inflation protection rider attached to the Policy.

Facility Services Benefit

Benefits are payable for Covered Expenses incurred for Qualified Long Term Care Services (including skilled, intermediate or custodial, nursing care), provided in a nursing facility or assisted living facility, Maintenance or Personal Care Services performed in an assisted living facility and hospice care provided in a hospice facility. Covered Expenses means the actual daily cost of each day's Facility Services received up to the Daily Benefit Amount. Premium rates will vary according to the Daily Benefit Amount selected.

Facility Prescription Drug Benefit

Benefits are payable for Covered Expenses incurred for prescription drugs when the Insured is receiving Facility Services under the Policy. Covered Expenses means the actual monthly cost of the Insured's prescription drugs up to the monthly maximum equal to the Daily Benefit Amount. This benefit is not payable if the Insured is receiving Home and Community Based Services or the Insured is confined in a hospital.

Facility Bed Reservation Benefit

Benefits are payable if Facility Services are being received in a nursing facility, assisted living facility or hospice facility and Covered Expenses are incurred for a Facility Bed Reservation. Covered Expenses means the actual cost charged by the Facility to reserve accommodations for each day the Insured is temporarily absent from the Facility, up to the Daily Benefit Amount. The Policy Year maximum for this benefit is sixty (60) times the Daily Benefit Amount.

Home and Community Based Services Benefit

Benefits are payable for Covered Expenses for Home and Community Based Services. Covered Expenses means the actual daily cost of each day's Home and Community Based Services received up to the Daily Benefit Amount. Benefits include home health care provided through a qualified Home Health Care Agency or Independent Home Health Caregiver, in a setting other than a hospital, nursing facility, assisted living facility or hospice facility. Home health care includes professional nursing care by or under the supervision of an RN or other licensed nurse; care by a qualified Home Health Aide; therapeutic care services by or under the supervision of a speech, occupational, physical, or respiratory therapist, licensed or certified under state law, if any; services provided by a registered dietician; or homemaker services. Benefits are also payable for adult day care and hospice care at home.

Emergency Response System Benefit

Benefits are payable for Covered Expenses if the Insured is receiving Home and Community Based Services benefits under the Policy. Covered Expenses means the actual monthly cost of the Insured's Emergency Response System, up to one-half (1/2) of the Daily Benefit Amount.

Ambulance Services Benefit

Benefits are payable for Covered Expenses if the Insured is receiving Home and Community Based Services benefits under the Policy. Covered Expenses means the actual cost of each day's Ambulance Services up to the Daily Benefit Amount. The Policy Year maximum for this benefit is four (4) times the Daily Benefit Amount.

Caregiver Training Benefit

Benefits are payable for Covered Expenses for training provided by a health care professional approved by Us, to an informal caregiver. Covered Expenses means the actual cost of the Caregiver Training up to the lifetime maximum of five (5) times the Daily Benefit Amount. The Insured is not required to satisfy the Elimination Period for the Policy before We will pay the Caregiver Training Benefit. Receipt of Caregiver Training by the informal caregiver does not count toward satisfaction of the Elimination Period for any other benefits payable under the Policy.

Respite Care Benefit

Benefits are payable for Covered Expenses for Qualified Long Term Care Services provided to the Insured on a short term basis to relieve an informal caregiver in the Insured's residence, a nursing facility, assisted living facility, or through a community based program. Covered Expenses means the actual cost up to the Daily Benefit Amount. The Policy Year maximum for this benefit is thirty (30) times the Daily Benefit Amount. The Insured is not required to satisfy the Elimination Period for the Policy before We will pay the Respite Care Benefit. Receipt of Respite Care does not count toward satisfaction of the Elimination Period for any other benefits payable under the Policy.

Alternative Plan of Care Benefit

Benefits are payable for Covered Expenses for an Alternative Plan of Care, for treatment or services not otherwise specified in the Policy, including, but not limited to, durable medical equipment and home modification. The Insured or the Insured's representative, the Insured's Licensed Health Care Practitioner and We must agree that the Alternative Plan of Care services are cost-effective; appropriate to the Insured's needs; provide the Insured with an equal or greater quality of care; and constitute Qualified Long Term Care Services. Covered Expenses means the actual cost of the Alternative Plan of Care services received. We reserve the right to make the final decision on any request for the Alternative Plan of Care Benefit.

Optional Personal Care Advisor Benefit

The Insured is entitled to the assistance of a Personal Care Advisor. The Insured or the Insured's representative, or a Family Member are encouraged to contact Our claim office as soon as a claim is anticipated by calling the toll-free number that will be shown on the Policy Schedule page of the Policy. We will then contact the Personal Care Services Provider and instruct them to assign a Personal Care Advisor to the Insured so that the Insured can obtain Personal Care Advisory Services as soon as possible.

If the Insured chooses to utilize the services of the Personal Care Advisor assigned by the Personal Care Advisory Services Provider, the costs of the Personal Care Advisory Services will be billed directly to Us and We will pay the Personal Care Advisory Services Provider directly. The cost of the Personal Care Advisory Services paid by Us will not reduce the Total Benefit Amount under the Policy.

The Insured is not required to satisfy the Elimination Period in order to use the services of a Personal Care Advisor. Use of the Personal Care Advisor does not count towards satisfaction of the Elimination Period. Use of a Personal Care Advisor is completely voluntary. The use or non-use of a Personal Care Advisor does not impact the right to benefits under the Policy.

Coverage Outside of the United States

Benefits are payable for Covered Expenses for Facility Services and Home and Community Based Services received Outside of the United States. Covered Expenses means the actual cost of each day's Facility Services or Home and Community Based Services received Outside of the United States, subject to Eligibility for the Payment of Benefits and the Elimination Period for Coverage Outside of the United States, as previously described. Benefits will be payable in United States currency at the conversion rate determined by the United States Treasury as of the date benefits are paid. Benefits will be payable up to one-half (1/2) of the Daily Benefit Amount. For policies with Total Benefit Amounts less than lifetime, a maximum of twenty-five percent (25%) of the Total Benefit Amount is payable under the Policy for this benefit. For policies with lifetime Total Benefit Amounts, the lifetime maximum for this benefit is 1,825 times the Daily Benefit Amount under the Policy.

While We are paying benefits for Coverage Outside of the United States, the following benefits will not be available: Facility Prescription Drug Benefit, Facility Bed Reservation Benefit, Emergency Response System Benefit, Ambulance Services Benefit, Caregiver Training Benefit, Respite Care Benefit, or the Alternative Plan of Care Benefit.

Definitions

Activities of Daily Living:

- **Bathing:** means washing oneself by sponge bath; or in either a tub or shower, including the task of getting into or out of the tub or shower.
- **Continence:** means the ability to maintain control of bowel and bladder function; or when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene (including caring for a catheter or colostomy bag).
- **Dressing:** means putting on and taking off all items of clothing and any necessary braces, fasteners, or artificial limbs.
- **Eating:** means feeding oneself by getting food into the body from a receptacle (such as a plate, cup, or table) or by a feeding tube or intravenously.
- **Toileting:** means getting to and from the toilet, getting on or off the toilet, and performing associated personal hygiene.
- **Transferring:** means moving into or out of bed, a chair, or wheelchair.

Ambulance Services means transportation by ambulance from the Insured's home to a facility, or to and from a facility for purposes of receiving Respite Care.

Beneficiary means the person or persons, named in the application or subsequently changed by written request, to receive payment of the return of earned premium benefit due upon the death of the Insured under the optional Return of Premium on Death Rider and the optional Full Return of Premium on Death Rider.

Chronically Ill means within the previous twelve (12) months a Licensed Health Care Practitioner has certified that the Insured:

- is unable to perform, without Substantial Assistance from another person, at least two (2) Activities of Daily Living for a period that is expected to last at least ninety (90) consecutive days due to loss of functional capacity; or
- has a Severe Cognitive Impairment.

Covered Expenses means the amount of benefit payable by Us as a result of the Insured's receipt of Qualified Long Term Care Services. The Covered Expense for each benefit available under the Policy is defined by the specific Benefit provision of the Policy.

Covered Partner means the Insured's spouse or Partner who is covered by Us under a policy with the same state policy form number as the Policy.

Emergency Response System means a personal service the Insured can alert easily (such as pressing a button on a bracelet or pendant) when in distress and in need of help. This does not include a home alarm system.

Family Member means the Insured's spouse (or Partner) and the following relatives by blood, marriage or adoption, of the Insured or the Insured's spouse (or Partner): grandparents; parents, aunts or uncles; siblings, first cousins; children, nieces, or nephews; and grandchildren.

Hands-On Assistance means the physical assistance of another person without which the Insured would be unable to perform the Activity of Daily Living.

Home Health Aide means a person, other than an RN or nurse, who provides Qualified Long Term Care Services through a Home Health Care Agency or as an Independent Home Health Caregiver. A Home Health Aide must be licensed or certified under state law, if any, and acting within the scope of his or her license or certification at the time the Qualified Long Term Care Services are performed.

Home Health Care Agency means an entity that is regularly engaged in providing Home Health Care for compensation and employs staff, qualified by training or experience, to provide such care. The entity must: keep clinical records or care plans on all patients; provide ongoing supervision and training to its employees appropriate to the services to be provided; and have the appropriate state licensure or certification, where required. If licensure or certification is not required, the entity must be supervised by a qualified professional such as a Registered Nurse (RN), a Licensed Social Worker, or a Physician.

Independent Home Health Caregiver means a certified nursing assistant, nurse, or physical, occupational, respiratory or speech therapist, or any other person approved by Us that meets all of the following criteria:

- is independently employed and not associated with a Home Health Care Agency;
- is qualified by training and experience to provide Qualified Long Term Care Services; and
- is licensed or certified under state law, if any, and acting within the scope of his or her license at the time the Qualified Long Term Care Services are provided.

Insured means the person named as the insured on the Policy Schedule page of the Policy.

Licensed Health Care Practitioner means:

- a physician;
- a registered nurse; or
- a licensed social worker.

The Licensed Health Care Practitioner must not be a Family Member.

Maintenance or Personal Care Services means any care the primary purpose of which is the provision of needed assistance with helping the Insured conduct Activities of Daily Living while Chronically Ill. This includes protection from threats to the Insured's health and safety due to a Severe Cognitive Impairment.

Outside of the United States means outside of the United States or its territories, or Canada.

Partner means an adult who is either:

- named along with the Insured, in a valid certificate or license of civil union recognized by the sate in which the Policy is issued; or
- has been living with the Insured for the past three (3) consecutive years in a committed relationship as the Insured's Partner or as a member of the Insured's family; and
  - is committed to sharing basic living expenses with the Insured; and
  - is not married to the Insured, or anyone else; and
  - if related to the Insured, belongs to the same generation of the Insured's family (e.g. brother, sister, or cousin).

Plan of Care means a written individualized plan of services prescribed by a Licensed Health Care Practitioner developed in consultation with the Insured, based upon an assessment that states the Insured is Chronically Ill. The Plan of Care will specify the type, frequency, and providers of the services most suitable to meet the Insured's long term care needs and the

costs, if any, of those services. The Plan of Care must be updated as the Insured's needs change. At all times We retain the right to verify that the Insured's Plan of Care is appropriate.

Policy means the contract between You and Us.

Policy Anniversary Date means the Policy Anniversary Date as shown on the Policy Schedule page of the Policy.

Policy Year means the period from the Policy effective date to the first Policy Anniversary Date or the period from one Policy Anniversary Date to the next Policy Anniversary Date.

Qualified Long Term Care Services means necessary diagnostic, preventive, therapeutic, curing, treating, mitigating and rehabilitative services, and Maintenance or Personal Care Services, which are required by the Insured when Chronically Ill, and are provided pursuant to a Plan of Care prescribed by a Licensed Health Care Practitioner.

Severe Cognitive Impairment means the deterioration or loss of intellectual capacity that is comparable to, and includes, Alzheimer's disease and similar forms of irreversible dementia which requires Substantial Supervision. Severe Cognitive Impairment is measured by clinical evidence and standardized tests that reliably measure a person's impairment in:

- short or long term memory;
- orientation as to person (such as the person's identity), place (such as the person's location) and time (such as day, date and year); and
- deductive or abstract reasoning.

Single Claim Period means a claim for benefits under the Policy that is not interrupted by a period of one hundred eighty (180) consecutive days. If the Insured does not meet the requirements of Eligibility for the Payment of Benefits under the Policy because the Insured is no longer Chronically Ill and no benefits are paid under the Policy for a period of one hundred eighty (180) consecutive days or longer, a new Single Claim Period will be established.

Stand-By Assistance means the presence of another person within arm's reach of the Insured that is necessary to prevent, by physical intervention, injury to the Insured while performing the Activity of Daily Living.

Substantial Assistance means Hands-On or Stand-By Assistance.

Substantial Supervision means continual supervision by another person to protect a person with a Severe Cognitive Impairment or others from threats to health or safety (such as may result from wandering). Such supervision may include cueing by verbal prompting, gestures, or other similar demonstrations.

Total Benefit Amount means the remaining amount of benefits that may be paid under the Policy. The initial Total Benefit Amount is shown on the Policy Schedule page of the Policy. The Total Benefit Amount after Policy issue will be decreased by benefits paid under the Policy. The Total Benefit Amount after Policy issue will be increased in accordance with the provisions of any riders attached to the Policy and any additional benefits resulting from the crediting of dividends.

We, Us, Our means Massachusetts Mutual Life Insurance Company.

You, Your means the owner of the Policy as indicated in Our records. The owner is the Insured unless otherwise provided in the application or changed by written request.

Eligibility for the Payment of Benefits

Subject to all the terms and provisions of the Policy, We will pay the Covered Expenses for benefits described in the Policy when We verify that the Insured meets all of the following conditions:

- the Insured is Chronically Ill;
- the Qualified Long Term Care Services the Insured receives are covered under the Policy and are provided pursuant to the Plan of Care;
- coverage under the Policy was in force on the date(s) the Qualified Long Term Care Services were received by the Insured;
- unless otherwise indicated within the Policy, the Insured has satisfied the Policy's Elimination Period;

- any daily, monthly, annual, or lifetime limits on the specific benefit(s) being claimed under the Policy or any attached riders to the Policy have not been exhausted;
- the Insured meets all additional requirements indicated in the Policy for the specific benefit(s) under the Policy;
- the requirements under the FILING A CLAIM section of the Policy have been satisfied; and
- the claim is not subject to the Limitations and Exclusions contained in the Policy.

LIMITATIONS OR CONDITIONS ON ELIGIBILITY FOR THE PAYMENT OF BENEFITS

Non-Eligible Facilities

A nursing facility does not include a hospital, clinic or assisted living facility, a convalescent home, a board and rest home, a home for the aged, an adult residential care facility, a domiciliary and retirement care facility, a training center, a government or veteran's facility or any other facility where the patient is not required to pay, or the Insured's primary place of residence in an area used principally for independent residential living, or a similar establishment. An assisted living facility does not include a hospital, a nursing facility, an individual residence, or an independent living unit.

No benefits will be paid under the Policy for confinement in:

- non-eligible facilities; or
- an unlicensed facility (if licensing is required in Your state).

Limitations and Exclusions

No benefits will be paid and the Elimination Period will not be satisfied for any confinement, care, treatment or service(s):

- provided to the Insured by a Family Member;
- provided Outside of the United States except as described previously under Coverage Outside of the United States;
- for which You or the Insured have no financial liability or that is provided at no charge in the absence of insurance;
- provided in facilities operated primarily for the treatment of alcoholism or drug addiction; or
- provided in facilities operated primarily for the treatment of mental or nervous disorders.

Non-Duplication of Benefits

Benefits are not payable under the Policy for: (a) expenses incurred to the extent that such expenses are reimbursable under Medicare or would be so reimbursable but for the application of a deductible or coinsurance amount; or (b) any other state or federal workers' compensation plan, or other governmental program (except Medicaid).

For purposes of satisfying the Elimination Period, days on which the Insured meets the requirements of Eligibility for the Payment of Benefits, but coverage is excluded due to the Non-Duplication of Benefits, will count toward satisfaction of the Elimination Period.

THE POLICY MAY NOT COVER ALL EXPENSES ASSOCIATED WITH YOUR LONG TERM CARE NEEDS.

RELATIONSHIP OF COST OF CARE AND BENEFITS

Because the costs of long term care services will likely increase over time, You should consider whether and how the benefits of this plan may be adjusted. The benefit levels of the basic Policy will not increase over time. For an additional premium payment, You may purchase one of the optional Inflation Protection Riders described below.

ALZHEIMER'S DISEASE AND OTHER ORGANIC BRAIN DISORDERS

Subject to Eligibility for the Payment of Benefits and any Limitations and Exclusions described above, the Policy provides coverage if the Insured is clinically diagnosed as having Alzheimer's disease or related degenerative and dementing illnesses.

PREMIUM

Premium Payment Options

10-Year and Paid-Up at Age 65 Premium Payments

These options provide that at the end of the premium payment period if each required premium has been paid, the Policy will automatically be renewed for the rest of the Insured's life with no further premium payments required. During the premium payment period, premiums will be subject to change as described under "TERMS UNDER WHICH THE POLICY MAY BE CONTINUED IN FORCE OR DISCONTINUED" on the first page of this outline of coverage.

Long Term Care Insurance Policy

** If a PARTNERSHIP POLICY is selected below and You are age **60 or younger**, Compound Inflation Protection must be selected and will be issued with Your Policy. If You are age **61-75**, either Compound or Simple Inflation Protection must be selected and will be issued with Your Policy.*

☒ Partnership Policy ☐ Non-Partnership Policy

☒ Covered Partner Discount (two applicants) ☐ Partner Discount (one applicant)

Elimination Period: ☐ 30 Days ☐ 60 Days ☒ 90 Days ☐ 180 Days

Daily Benefit ($50 - $400): $ $100.00

Benefit Period:
- ☐ Lifetime
- ☐ 3,650 Days (10 Years)
- ☐ 2,190 Days (6 Years)
- ☐ 1,825 Days (5 Years)
- ☐ 1,460 Days (4 Years)
- ☒ 1,095 Days (3 Years)
- ☐ 730 Days (2 Years)

Premium Payment: ☒ Standard Premium ☐ Discounted Renewals Premium

Premium Payment Options: ☐ Lifetime Premium ☒ 10-Year Premium ☐ Paid-Up at Age 65 Premium

The following are the Annual Premiums for the coverage You have applied for:

Comprehensive coverage is Facility Services plus Home and Community Based Services (HCBS)

	First Year	Renewal
☒ Comprehensive Long Term Care Insurance Policy	$ 463.66	$ 463.66
☐ Comprehensive with Indemnity Benefit Rider (Form MM500R-IND-1)	$	$
☐ Comprehensive with HCBS Monthly Benefit Rider (Form MM500R-MTH)	$	$
Inflation Protection Riders (may select only one) *		
☒ Compound (Form MM500R-CIP)	$ 664.42	$ 664.42
☐ Simple (Form MM500R-SIP)	$	$
Return of Premium Riders (may select only one)		
☐ Full Return of Premium on Death *(available to age 65)* (Form MM500R-FROP)	$	$
☐ Return of Premium on Death (Form MM500R-ROP)	$	$
Elimination Period Riders (may select only one)		
☐ Enhanced Elimination Period (Form MM500R-EEP)	$	$
☐ HCBS Waiver of the Elimination Period (Form MM500R-WOE)	$	$
Other Riders		
☒ Shortened Benefit Period Nonforfeiture (Form MM500R-SBN)	$ 225.52	$ 225.52
☐ Restoration of Benefits *(not available with Lifetime Benefit Period)* (Form MM500R-ROB)	$	$
(if applying as Covered Partners, both must select any of the following riders)		
☒ Waiver of Premium for Covered Partner (Form MM500R-WOP)	$ 22.57	$ 22.57
☐ Paid-Up Survivor Benefit *(available only with Lifetime Premium Payment Option)* (Form MM500R-SVR)	$	$
☐ Shared Care Benefit **(Covered Partner coverage must be identical)** *(not available with Lifetime Benefit Period)* (Form MM500R-SCB)	$	$
Additional Premium for 10-Year or Paid-Up at Age 65 Premium Payment Options	$ 2,369.77	$ 2,369.77
TOTAL ANNUAL PREMIUM	$ 2,434.86	$ 2,434.86

ADDITIONAL FEATURES

Medical Underwriting

The Insured's insurability for the Policy will be determined by the answers given in the Application and any other authorized medical information We obtain regarding the Insured's current state of health.

Grace Period

Except for the first premium, You will have thirty-one (31) days after each due date to pay the premium due. The Policy remains in force during the Grace Period.

Unintentional Lapse

If the premium is not paid by the thirtieth (30th) day of the Grace Period, We will provide written notice to You and the Insured, if different, and any individuals designated by You or the Insured, if different, to receive notice of non-payment of premium. Notice will be sent at least thirty (30) days before cancellation of Your coverage. If the premium is not paid within thirty-five (35) days after notice is sent, the Policy will lapse for non-payment of premium.

Dividends

While the Policy is in force, We may credit it with dividends. Dividends are based on divisible surplus, if any, as We apportion at the end of each Policy Year. Dividends credited to the Policy will be used to reduce the future premiums for the Policy. If the Policy is not in premium paying status, the dividends will be used to increase the future benefits of the Policy. Dividends, if any, are not anticipated to be credited before the later of the later of (a) the Policy Anniversary Date after the Insured attains sixty-five (65) years of age, or (b) the tenth (10th) Policy Anniversary Date.

Nonforfeiture Benefits

If You choose not to select the following optional nonforfeiture rider, a contingent benefit upon lapse will be available if: (a) the Policy lapses as described under the Grace Period and Unintentional Lapse provisions of the Policy; and (b) the premium rates for the Policy are substantially increased. The benefit provided will be in the form of a Shortened Benefit Period as described below.

In addition to the contingent nonforfeiture benefit described above, if You select a limited premium payment option an additional contingent nonforfeiture benefit may also be available in the form of a reduced "paid-up" policy.

OPTIONAL RIDERS (available for an additional premium payment)

Shortened Benefit Period Nonforfeiture

The rider provides a benefit when the Policy lapses, after being in force for at least three (3) years, due to the non-payment of premium. The Policy will become paid-up with modified coverage based on the Daily Benefit Amount in effect immediately prior to the date of lapse. The Total Benefit Amount payable under the rider will be reduced to the greater of: (a) the total of all premiums paid prior to the date of lapse for the Policy and all riders or (b) thirty (30) times the Daily Benefit Amount in effect immediately prior to the date of lapse of the Policy.

Full Return of Premium on Death

If the Insured dies while the Policy is in force, We will pay to Your Beneficiary a benefit equal to the total of all earned premiums paid for the Policy and all attached riders. In the event You have not designated a Beneficiary, this amount will be paid to You, if living, or to Your estate. Upon death of the Insured, We will refund any unearned premium for the Policy on a pro-rata basis.

Return of Premium on Death

If the Insured dies while the Policy is in force, We will pay to Your Beneficiary a benefit equal to the total of all earned premiums paid for the Policy and all attached riders, less all benefits paid under the Policy. In the event You have not designated a Beneficiary, this amount will be paid to You, if living, or to Your estate. Upon death of the Insured, We will refund any unearned premium for the Policy on a pro-rata basis.

Indemnity Benefit

The rider will pay the full Daily Benefit Amount for Facility Services or Home and Community Based Services up to a Per Diem Maximum. If the Covered Expenses exceed the Per Diem Maximum, the rider will pay the Covered Expenses. The Per Diem Maximum is the dollar amount used to determine the Per Diem limitation described in Section 7702B of the Internal Revenue Code.

Enhanced Elimination Period

The rider modifies the previously described Elimination Period and provides that if the Insured receives at least one (1) day of Facility Services or Home and Community Based Services within a seven (7)-day period (Sunday through Saturday), We will credit seven (7) days toward satisfaction of the Elimination Period.

Home and Community Based Services Waiver of Elimination Period

The rider will waive the requirement to satisfy the Elimination Period for purposes of receiving benefits under the Home and Community Based Services Benefit. Days for which a Home and Community Based Services Benefit is paid for under the rider are credited towards the satisfaction of the Elimination Period for other benefits under the Policy. However, no days will be credited toward satisfaction of the Elimination Period for Coverage Outside of the United States.

Waiver of Premium for Covered Partner

The rider will waive the premium payments for the Policy to which the rider is attached during any period in which the premium payments for the Covered Partner's policy are waived. A Waiver of Premium for Covered Partner must be issued with and remain attached to the Covered Partner's policy. Both the Policy, including the rider and the Covered Partner's policy, including the rider, must remain in force. If both policies or the rider do not remain in force, the rider will terminate and the premium for the rider will end.

Home and Community Based Services Monthly Benefit

The rider replaces the Home and Community Based Services daily reimbursement limit with a monthly reimbursement limit. We will pay a benefit equal to Covered Expenses incurred. Covered Expenses means the actual cost of Home and Community Based Services received during a calendar month, up to the Monthly Benefit Amount. The Monthly Benefit Amount for a given calendar month is equal to the Daily Benefit Amount times thirty-one (31), less any Facility Services Benefits received during that calendar month.

Restoration of Benefits

The rider will restore the Total Benefit Amount selected to its original amount and then adjust for the effects of an inflation protection rider, if any, attached to the Policy, if We pay benefits under the Policy and the Insured subsequently Recovers. Under the rider, Recovers means that the Insured has not exhausted the Total Benefit Amount and for a period of one hundred eighty (180) consecutive days prior to the date the benefits are restored the following three (3) conditions are satisfied: (a) the Policy is in force and premiums are not waived; (b) the Insured is no longer Chronically Ill; and (c) We have not paid benefits under the Policy during the one hundred eighty (180) consecutive days. Benefits may be restored more than once. However, the rider will terminate and the premium for the rider will no longer be due when the total of all amounts, adjusted for the effects of an inflation protection rider, if any, attached to the Policy, restored over the lifetime of the rider is equal to the original Total Benefit Amount. The rider will terminate when the Total Benefit Amount of the Policy is exhausted. In the event You cancel or the Policy lapses due to non-payment of premium, the rider will also terminate.

Paid-Up Survivor Benefit

The rider provides that the Policy to which the rider is attached will be paid-up and no further premium payments required after both of the following have occurred: (a) the tenth (10th) Policy Anniversary Date; and (b) the date of the Covered Partner's death. If the Covered Partner dies before the tenth (10th) Policy Anniversary Date, the premium for the Policy must continue to be paid, including the rider, until the tenth (10th) Policy Anniversary Date, unless waived under the Policy, at which point the Policy will be paid-up and no further premium payments will be required. A Paid-Up Survivor Benefit Rider must be issued with and remain attached to the Covered Partner's policy. Both the Policy, including the

rider and the Covered Partner's policy, including the rider, must remain in force. If both policies, or the rider do not remain in force, the rider will terminate and the premium for the rider will end. In the event You cancel or the Policy lapses due to non-payment of premium, the rider will terminate.

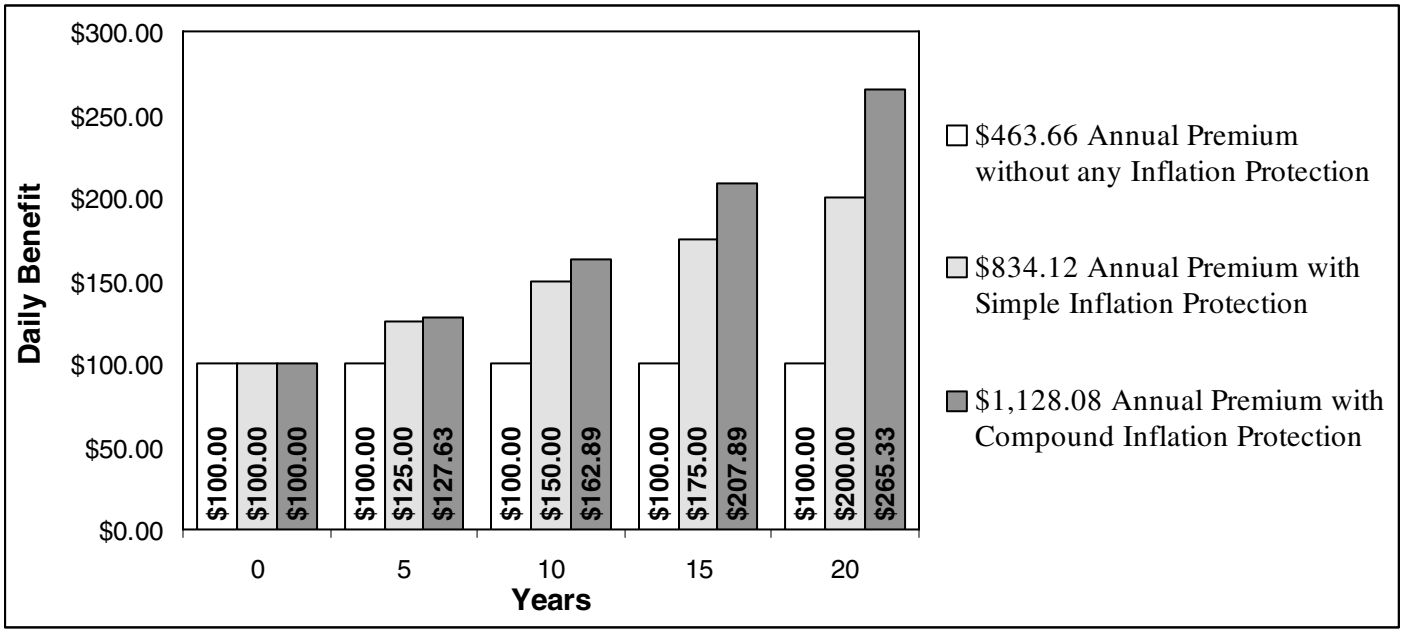
Shared Care Rider

The rider provides for a Shared Total Benefit Amount for Covered Partners in the event that the Total Benefit Amount for the Policy has been exhausted, the Policy will remain in force and We may continue to pay benefits in accordance with the provisions of the Policy until the Shared Total Benefit Amount has also been exhausted. The Policy will terminate on the date that both the Total Benefit Amount and the Shared Benefit Amount are exhausted. The Shared Benefit Amount will be reduced by benefits paid under the Policy and by benefits paid under the Shared Care Rider attached to the Covered Partner's policy. The Shared Benefit Amount will be increased in accordance with any inflation protection rider attached to the Policy. If the Covered Partner dies, the Shared Total Benefit Amount will remain available for as long as the Policy including the rider remain in force. The Policy and the Covered Partner's policy must be identical at the time of purchase and remain in force as identical policies (policy form, Total Benefit Amount, Elimination Period, Daily Benefit Amount, and all attached riders and endorsements). If identical policies do not remain in force, the rider will terminate and the premium for the rider with end. In the event the Policy lapses due to non-payment of premium, the rider will terminate.

Inflation Protection

These riders provide that on each Policy Anniversary Date, while the Policy to which the riders are attached remains in force, including while We are paying benefits, We will increase the Daily Benefits. The Compound Inflation Protection Rider increases the Daily Benefit Amount and Total Benefit Amount in effect immediately prior to the Policy Anniversary Date by five percent (5%). The Simple Inflation Protection Rider increases the Daily Benefit Amount in effect immediately prior to the Policy Anniversary Date by five percent (5%) of the original Daily Benefit Amount in effect at the time the Policy was issued and the Total Benefit Amount by an amount equal to the proportional increase in the Daily Benefit Amount.

The following graph compares the benefits and premiums between a policy with the Compound Inflation Protection Rider, a policy with the Simple Inflation Protection Rider and a policy without either rider. For purposes of illustration, the sample shown is for a policy with a 1,095-day (3-Year) Benefit Period for Facility Services and Home and Community Based Services, issued at age fifty-five (55), a ninety (90) day Elimination Period, and a one hundred dollar ($100.00) Daily Benefit Amount.



Agent

Address

Phone Number

CONTACT THE STATE SENIOR HEALTH INSURANCE ASSISTANCE PROGRAM IF YOU HAVE GENERAL QUESTIONS REGARDING LONG TERM CARE INSURANCE. CONTACT THE INSURANCE COMPANY IF YOU HAVE SPECIFIC QUESTIONS REGARDING YOUR LONG TERM CARE INSURANCE POLICY.

Massachusetts Mutual Life Insurance Company

Home Office: Springfield, MA 01111-0001
Long Term Care Administrative Office
P.O. Box 4243
Woodland Hills, CA 91365-4243
888.505.8952

Outline of Coverage for Facility Services Only Insurance Policy Form MM501-P-AR

NOTICE TO BUYER: This Policy may not cover all of the costs associated with long term care incurred by the buyer during the period of coverage. The buyer is advised to review carefully all Policy limitations.

Caution: The issuance of this Facility Services Only Insurance Policy is based upon the responses to the questions on the Application. A copy of the Application is enclosed. If the responses are incorrect or untrue, the Company may have the right to deny benefits or rescind the Policy. The best time to clear up any questions is now, before a claim arises! If, for any reason, any of the responses are incorrect, contact Us at the Long Term Care Administrative Office address shown above.

The Policy is an individual Policy of insurance.

PURPOSE OF OUTLINE OF COVERAGE

This outline of coverage provides a very brief description of the important features of the Policy. You should compare this outline of coverage to outlines of coverage for other policies available to You. This is not the insurance contract, but only a summary of coverage. Only the individual Policy contains governing contractual provisions. This means that the Policy sets forth in detail the rights and obligations of both You and the Company. Therefore, if You purchase this coverage, or any other coverage, it is important that You READ YOUR POLICY CAREFULLY!

FEDERAL TAX CONSEQUENCES

THE POLICY IS INTENDED TO BE A FEDERALLY TAX-QUALIFIED LONG TERM CARE INSURANCE CONTRACT AS DEFINED UNDER SECTION 7702B(b) OF THE INTERNAL REVENUE CODE OF 1986, as amended, and will be endorsed to conform to changes in that definition. You should consult with Your attorney, accountant, or tax advisor regarding the tax implications of purchasing this long term care insurance.

TERMS UNDER WHICH THE POLICY MAY BE CONTINUED IN FORCE OR DISCONTINUED

RENEWABILITY: THE POLICY IS GUARANTEED RENEWABLE. This means You have the right, subject to the terms of the Policy, to continue the Policy as long as You pay Your premiums on time. Massachusetts Mutual Life Insurance Company cannot change any of the terms of the Policy on its own, except that, in the future, IT MAY INCREASE THE PREMIUM YOU PAY.

Waiver of Premium

Premiums will not be due once We begin paying, and for as long as We continue to pay, benefits for Facility Services under the Policy. We will return any unearned premium to You on a pro-rata basis. Premium will again become due when We are no longer paying You because the Insured is no longer receiving Facility Services.

For an additional premium payment, an optional Waiver of Premium for Covered Partner Rider is also available, as described below.

TERMS UNDER WHICH THE COMPANY MAY CHANGE PREMIUMS

Premiums are subject to change. We can only change the premiums for the Policy if We change premiums, subject to the approval of the appropriate regulatory authority of the state in which this Policy was issued. We will give You at least sixty (60) days written notice at Your last address shown in Our records before We change Your premium.

TERMS UNDER WHICH THE POLICY MAY BE RETURNED AND PREMIUM REFUNDED

If You are not satisfied with the Policy, You may return it to Our agent or Us within thirty (30) days from the date You receive it. We will then refund any premium You have paid and the Policy, all riders and attachments will be considered never to have been in effect. Upon the death of the Insured, We will refund any unearned premium for the Policy on a pro-rata basis. We will make this refund within thirty (30) days of Our receipt of proof of the Insured's death. If You cancel the Policy after thirty (30) days, any unearned premium will be refunded to You on a pro-rata basis. If You purchase one of the optional Return of Premium Riders, upon the death of the Insured, all or a portion of the premiums paid for the Policy and riders will be returned to You, if other than the Insured, or Your Beneficiary.

THIS IS NOT MEDICARE SUPPLEMENT COVERAGE

If the Insured is eligible for Medicare, review the "Guide to Health Insurance for People with Medicare" available from Us. Neither Massachusetts Mutual Life Insurance Company nor its agents represent Medicare, the federal government or any state government.

LONG TERM CARE COVERAGE

Policies of this category are designed to provide coverage for one (1) or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, Maintenance or Personal Care Services, provided in a setting other than an acute care unit of a hospital, such as in a nursing home.

The Policy provides coverage for Qualified Long Term Care Services in the form of an expense incurred benefit for covered long term care expenses, subject to Policy Elimination Periods, Limitations and Exclusions described below.

BENEFITS PROVIDED BY THE POLICY

Covered Services

The Policy provides benefits for Qualified Long Term Care Services performed in a nursing facility or assisted living facility, and Maintenance or Personal Care Services performed in an assisted living facility and hospice care provided in a hospice facility. A Prescription Drug Benefit and Bed Reservation Benefit are available if Facility Services are being received in a nursing facility, assisted living facility or hospice facility.

Elimination Period

This is the number of days the Insured must receive Facility Services, as defined in the Policy, pursuant to a Plan of Care, while the Policy is in force and the Insured is certified as being Chronically Ill, before We will begin paying benefits. An Elimination Period of thirty (30), sixty (60), ninety (90) or one hundred eighty (180) days may be chosen. For each day the Insured receives Facility Services, We will credit one (1) day toward satisfaction of the Elimination Period. These days do not need to be consecutive. Once the Insured has satisfied the Elimination Period, no future Elimination Period is required. Days may be accumulated under separate claims in order to satisfy the Elimination Period.

Elimination Period for Coverage Outside of the United States

This is the number of days after the Insured has satisfied the Elimination Period previously described and receives Facility Services Outside of the United States, as defined in the Policy, pursuant to a Plan of Care, while the Policy is in force and the Insured is certified as being Chronically Ill, before We will begin paying benefits for coverage Outside of the United States. Days on which the Insured receives Facility Services Outside of the United States will first be used to satisfy the Elimination Period previously described. Once this Elimination Period has been satisfied, We will credit one (1) day towards satisfaction of the Elimination Period for Coverage Outside of the United States. This number of days will be equal to the number of days selected for the Elimination Period previously described. These days do not need to be consecutive; however, days will not be accumulated under separate claims in order to satisfy the Elimination Period for Coverage Outside of the United States. The Insured must first satisfy the Elimination Period before days will count towards satisfaction of the Elimination Period for Coverage Outside of the United States.

Total Benefit Amount

An unlimited Total Benefit Amount may be chosen for Lifetime coverage, or a lesser amount determined by multiplying the Daily Benefit Amount chosen by the Benefit Period selected - either 3,650 days (10 Years), 2,190 days (6 Years),

1,825 days (5 Years), 1,460 days (4 Years), 1,095 days (3 Years) or 730 days (2 Years). The result will be the Total Benefit Amount for all benefits payable under the Policy.

Daily Benefit Amount

The initial Daily Benefit Amount will be shown on the Policy Schedule page of the Policy. The current Daily Benefit Amount will be the initial Daily Benefit Amount adjusted to reflect the provisions of any inflation protection rider attached to the Policy.

Facility Services Benefit

Benefits are payable for Covered Expenses incurred for Qualified Long Term Care Services (including skilled, intermediate or custodial, nursing care), provided in a nursing facility or assisted living facility, Maintenance or Personal Care Services performed in an assisted living facility and hospice care provided in a hospice facility. Covered Expenses means the actual daily cost of each day's Facility Services received up to the Daily Benefit Amount. Premium rates will vary according to the Daily Benefit Amount selected.

Facility Prescription Drug Benefit

Benefits are payable for Covered Expenses incurred for prescription drugs when the Insured is receiving Facility Services under the Policy. Covered Expenses means the actual monthly cost of the Insured's prescription drugs up to the monthly maximum equal to the Daily Benefit Amount. This benefit is not payable if the Insured is confined in a hospital.

Facility Bed Reservation Benefit

Benefits are payable if Facility Services are being received in a nursing facility, assisted living facility or hospice facility and Covered Expenses are incurred for a Facility Bed Reservation. Covered Expenses means the actual cost charged by the Facility to reserve accommodations for each day the Insured is temporarily absent from the Facility, up to the Daily Benefit Amount. The Policy Year maximum for this benefit is sixty (60) times the Daily Benefit Amount.

Optional Personal Care Advisor Benefit

The Insured is entitled to the assistance of a Personal Care Advisor. The Insured or the Insured's representative, or a Family Member are encouraged to contact Our claim office as soon as a claim is anticipated by calling the toll-free number that will be shown on the Policy Schedule page of the Policy. We will then contact the Personal Care Services Provider and instruct them to assign a Personal Care Advisor to the Insured so that the Insured can obtain Personal Care Advisory Services as soon as possible.

If the Insured chooses to utilize the services of the Personal Care Advisor assigned by the Personal Care Advisory Services Provider, the costs of the Personal Care Advisory Services will be billed directly to Us and We will pay the Personal Care Advisory Services Provider directly. The cost of the Personal Care Advisory Services paid by Us will not reduce the Total Benefit Amount under the Policy.

The Insured is not required to satisfy the Elimination Period in order to use the services of a Personal Care Advisor. Use of the Personal Care Advisor does not count towards satisfaction of the Elimination Period. Use of a Personal Care Advisor is completely voluntary. The use or non-use of a Personal Care Advisor does not impact the right to benefits under the Policy.

Coverage Outside of the United States

Benefits are payable for Covered Expenses for Facility Services received Outside of the United States. Covered Expenses means the actual cost of each day's Facility Services received Outside of the United States, subject to Eligibility for the Payment of Benefits and the Elimination Period for Coverage Outside of the United States, as previously described. Benefits will be payable in United States currency at the conversion rate determined by the United States Treasury as of the date benefits are paid. Benefits will be payable up to one-half (1/2) of the Daily Benefit Amount. For policies with Total Benefit Amounts less than lifetime, a maximum of twenty-five percent (25%) of the Total Benefit Amount is payable under the Policy for this benefit. For policies with lifetime Total Benefit Amounts, the lifetime maximum for this benefit is 1,825 times the Daily Benefit Amount under the Policy.

While We are paying benefits for Coverage Outside of the United States, the following benefits will not be available: Facility Prescription Drug Benefit or the Facility Bed Reservation Benefit.

Definitions

Activities of Daily Living:

- **Bathing:** means washing oneself by sponge bath; or in either a tub or shower, including the task of getting into or out of the tub or shower.
- **Continence:** means the ability to maintain control of bowel and bladder function; or when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene (including caring for a catheter or colostomy bag).
- **Dressing:** means putting on and taking off all items of clothing and any necessary braces, fasteners, or artificial limbs.
- **Eating:** means feeding oneself by getting food into the body from a receptacle (such as a plate, cup, or table) or by a feeding tube or intravenously.
- **Toileting:** means getting to and from the toilet, getting on or off the toilet, and performing associated personal hygiene.
- **Transferring:** means moving into or out of bed, a chair, or wheelchair.

Beneficiary means the person or persons, named in the application or subsequently changed by written request, to receive payment of the return of earned premium benefit due upon the death of the Insured under the optional Return of Premium on Death Rider and the optional Full Return of Premium on Death Rider.

Chronically Ill means within the previous twelve (12) months a Licensed Health Care Practitioner has certified that the Insured:

- is unable to perform, without Substantial Assistance from another person, at least two (2) Activities of Daily Living for a period that is expected to last at least ninety (90) consecutive days due to loss of functional capacity; or
- has a Severe Cognitive Impairment.

Covered Expenses means the amount of benefit payable by Us as a result of the Insured's receipt of Qualified Long Term Care Services. The Covered Expense for each benefit available under the Policy is defined by the specific Benefit provision of the Policy.

Covered Partner means the Insured's spouse or Partner who is covered by Us under a policy with the same state policy form number as the Policy.

Family Member means the Insured's spouse (or Partner) and the following relatives by blood, marriage or adoption, of the Insured or the Insured's spouse (or Partner): grandparents; parents, aunts or uncles; siblings, first cousins; children, nieces, or nephews; and grandchildren.

Hands-On Assistance means the physical assistance of another person without which the Insured would be unable to perform the Activity of Daily Living.

Insured means the person named as the insured on the Policy Schedule page of the Policy.

Licensed Health Care Practitioner means:

- a physician;
- a registered nurse; or
- a licensed social worker.

The Licensed Health Care Practitioner must not be a Family Member.

Maintenance or Personal Care Services means any care the primary purpose of which is the provision of needed assistance with helping the Insured conduct Activities of Daily Living while Chronically Ill. This includes protection from threats to the Insured's health and safety due to a Severe Cognitive Impairment.

Outside of the United States means outside of the United States or its territories, or Canada.

Partner means an adult who is either:

- named along with the Insured, in a valid certificate or license of civil union recognized by the sate in which the Policy is issued; or
- has been living with the Insured for the past three (3) consecutive years in a committed relationship as the Insured's Partner or as a member of the Insured's family; and
  - is committed to sharing basic living expenses with the Insured; and
  - is not married to the Insured, or anyone else; and
  - if related to the Insured, belongs to the same generation of the Insured's family (e.g. brother, sister, or cousin).

Plan of Care means a written individualized plan of services prescribed by a Licensed Health Care Practitioner developed in consultation with the Insured, based upon an assessment that states the Insured is Chronically Ill. The Plan of Care will specify the type, frequency, and providers of the services most suitable to meet the Insured's long term care needs and the costs, if any, of those services. The Plan of Care must be updated as the Insured's needs change. At all times We retain the right to verify that the Insured's Plan of Care is appropriate.

Policy means the contract between You and Us.

Policy Anniversary Date means the Policy Anniversary Date as shown on the Policy Schedule page of the Policy.

Policy Year means the period from the Policy effective date to the first Policy Anniversary Date or the period from one Policy Anniversary Date to the next Policy Anniversary Date.

Qualified Long Term Care Services means necessary diagnostic, preventive, therapeutic, curing, treating, mitigating and rehabilitative services, and Maintenance or Personal Care Services, which are required by the Insured when Chronically Ill, and are provided pursuant to a Plan of Care prescribed by a Licensed Health Care Practitioner.

Severe Cognitive Impairment means the deterioration or loss of intellectual capacity that is comparable to, and includes, Alzheimer's disease and similar forms of irreversible dementia which requires Substantial Supervision. Severe Cognitive Impairment is measured by clinical evidence and standardized tests that reliably measure a person's impairment in:

- short or long term memory;
- orientation as to person (such as the person's identity), place (such as the person's location) and time (such as day, date and year); and
- deductive or abstract reasoning.

Single Claim Period means a claim for benefits under the Policy that is not interrupted by a period of one hundred eighty (180) consecutive days. If the Insured does not meet the requirements of Eligibility for the Payment of Benefits under the Policy because the Insured is no longer Chronically Ill and no benefits are paid under the Policy for a period of one hundred eighty (180) consecutive days or longer, a new Single Claim Period will be established.

Stand-By Assistance means the presence of another person within arm's reach of the Insured that is necessary to prevent, by physical intervention, injury to the Insured while performing the Activity of Daily Living.

Substantial Assistance means Hands-On or Stand-By Assistance.

Substantial Supervision means continual supervision by another person to protect a person with a Severe Cognitive Impairment or others from threats to health or safety (such as may result from wandering). Such supervision may include cueing by verbal prompting, gestures, or other similar demonstrations.

Total Benefit Amount means the remaining amount of benefits that may be paid under the Policy. The initial Total Benefit Amount is shown on the Policy Schedule page of the Policy. The Total Benefit Amount after Policy issue will be decreased by benefits paid under the Policy. The Total Benefit Amount after Policy issue will be increased in accordance with the provisions of any riders attached to the Policy and any additional benefits resulting from the crediting of dividends.

We, Us, Our means Massachusetts Mutual Life Insurance Company.

You, Your means the owner of the Policy as indicated in Our records. The owner is the Insured unless otherwise provided in the application or changed by written request.

Eligibility for the Payment of Benefits

Subject to all the terms and provisions of the Policy, We will pay the Covered Expenses for benefits described in the Policy when We verify that the Insured meets all of the following conditions:

- the Insured is Chronically Ill;
- the Qualified Long Term Care Services the Insured receives are covered under the Policy and are provided pursuant to the Plan of Care;
- coverage under the Policy was in force on the date(s) the Qualified Long Term Care Services were received by the Insured;
- unless otherwise indicated within the Policy, the Insured has satisfied the Policy's Elimination Period;
- any daily, monthly, annual, or lifetime limits on the specific benefit(s) being claimed under the Policy or any attached riders to the Policy have not been exhausted;
- the Insured meets all additional requirements indicated in the Policy for the specific benefit(s) under the Policy;
- the requirements under the FILING A CLAIM section of the Policy have been satisfied; and
- the claim is not subject to the Limitations and Exclusions contained in the Policy.

LIMITATIONS OR CONDITIONS ON ELIGIBILITY FOR THE PAYMENT OF BENEFITS

Non-Eligible Facilities

A nursing facility does not include a hospital, clinic or assisted living facility, a convalescent home, a board and rest home, a home for the aged, an adult residential care facility, a domiciliary and retirement care facility, a training center, a government or veteran's facility or any other facility where the patient is not required to pay, or the Insured's primary place of residence in an area used principally for independent residential living, or a similar establishment. An assisted living facility does not include a hospital, a nursing facility, an individual residence, or an independent living unit.

No benefits will be paid under the Policy for confinement in:

- non-eligible facilities; or
- an unlicensed facility (if licensing is required in Your state).

Limitations and Exclusions

No benefits will be paid and the Elimination Period will not be satisfied for any confinement, care, treatment or service(s):

- provided to the Insured by a Family Member;
- provided Outside of the United States except as described previously under Coverage Outside of the United States;
- for which You or the Insured have no financial liability or that is provided at no charge in the absence of insurance;
- provided in facilities operated primarily for the treatment of alcoholism or drug addiction; or
- provided in facilities operated primarily for the treatment of mental or nervous disorders.

Non-Duplication of Benefits

Benefits are not payable under the Policy for: (a) expenses incurred to the extent that such expenses are reimbursable under Medicare or would be so reimbursable but for the application of a deductible or coinsurance amount; or (b) any other state or federal workers' compensation plan, or other governmental program (except Medicaid).

For purposes of satisfying the Elimination Period, days on which the Insured meets the requirements of Eligibility for the Payment of Benefits, but coverage is excluded due to the Non-Duplication of Benefits, will count toward satisfaction of the Elimination Period.

THE POLICY MAY NOT COVER ALL EXPENSES ASSOCIATED WITH YOUR LONG TERM CARE NEEDS.

RELATIONSHIP OF COST OF CARE AND BENEFITS

Because the costs of long term care services will likely increase over time, You should consider whether and how the benefits of this plan may be adjusted. The benefit levels of the basic Policy will not increase over time. For an additional premium payment, You may purchase one of the optional Inflation Protection Riders described below.

ALZHEIMER'S DISEASE AND OTHER ORGANIC BRAIN DISORDERS

Subject to Eligibility for the Payment of Benefits and any Limitations and Exclusions described above, the Policy provides coverage if the Insured is clinically diagnosed as having Alzheimer's disease or related degenerative and dementing illnesses.

PREMIUM

Premium Payment Options

10-Year and Paid-Up at Age 65 Premium Payments

These options provide that at the end of the premium payment period if each required premium has been paid, the Policy will automatically be renewed for the rest of the Insured's life with no further premium payments required. During the premium payment period, premiums will be subject to change as described under "TERMS UNDER WHICH THE POLICY MAY BE CONTINUED IN FORCE OR DISCONTINUED" on the first page of this outline of coverage.

Facility Services Only Insurance Policy

** If a PARTNERSHIP POLICY is selected below and You are age **60 or younger**, Compound Inflation Protection must be selected and will be issued with Your Policy. If You are age **61-75**, either Compound or Simple Inflation Protection must be selected and will be issued with Your Policy.*

☒ Partnership Policy ☐ Non-Partnership Policy

☒ Covered Partner Discount (two applicants) ☐ Partner Discount (one applicant)

Elimination Period: ☐ 30 Days ☐ 60 Days ☒ 90 Days ☐ 180 Days

Daily Benefit ($50 - $400): $ $100.00

Benefit Period:
- ☐ Lifetime
- ☐ 3,650 Days (10 Years)
- ☐ 2,190 Days (6 Years)
- ☐ 1,825 Days (5 Years)
- ☐ 1,460 Days (4 Years)
- ☒ 1,095 Days (3 Years)
- ☐ 730 Days (2 Years)

Premium Payment: ☒ Standard Premium ☐ Discounted Renewals Premium

Premium Payment Options: ☐ Lifetime Premium ☒ 10-Year Premium ☐ Paid-Up at Age 65 Premium

The following are the Annual Premiums for the coverage You have applied for:

	First Year	Renewal
☒ Facility Services Only Insurance Policy	$ 394.26	$ 394.26
Inflation Protection Riders (may select only one) *		
☒ Compound (Form MM500R-CIP)	$ 564.97	$ 564.97
☐ Simple (Form MM500R-SIP)	$	$
Return of Premium Riders (may select only one)		
☐ Full Return of Premium on Death *(available to age 65)* (Form MM500R-FROP)	$	$
☐ Return of Premium on Death (Form MM500R-ROP)	$	$
Other Riders		
☒ Shortened Benefit Period Nonforfeiture (Form MM500R-SBN)	$ 191.77	$ 191.77
☐ Restoration of Benefits *(not available with Lifetime Benefit Period)* (Form MM500R-ROB)	$	$
(if applying as Covered Partners, both must select any of the following riders)		
☒ Waiver of Premium for Covered Partner (Form MM500R-WOP)	$ 19.19	$ 19.19
☐ Paid-Up Survivor Benefit *(available only with Lifetime Premium Payment Option)* (Form MM500R-SVR)	$	$
☐ Shared Care Benefit **(Covered Partner coverage must be identical)** *(not available with Lifetime Benefit Period)* (Form MM500R-SCB)	$	$
Additional Premium for 10-Year or Paid-Up at Age 65 Premium Payment Options	$ 2,015.07	$ 2,015.07
TOTAL ANNUAL PREMIUM	$ 2,070.42	$ 2,070.42

ADDITIONAL FEATURES

Medical Underwriting

The Insured's insurability for the Policy will be determined by the answers given in the Application and any other authorized medical information We obtain regarding the Insured's current state of health.

Grace Period

Except for the first premium, You will have thirty-one (31) days after each due date to pay the premium due. The Policy remains in force during the Grace Period.

Unintentional Lapse

If the premium is not paid by the thirtieth (30th) day of the Grace Period, We will provide written notice to You and the Insured, if different, and any individuals designated by You or the Insured, if different, to receive notice of non-payment of premium. Notice will be sent at least thirty (30) days before cancellation of Your coverage. If the premium is not paid within thirty-five (35) days after notice is sent, the Policy will lapse for non-payment of premium.

Dividends

While the Policy is in force, We may credit it with dividends. Dividends are based on divisible surplus, if any, as We apportion at the end of each Policy Year. Dividends credited to the Policy will be used to reduce the future premiums for the Policy. If the Policy is not in premium paying status, the dividends will be used to increase the future benefits of the Policy. Dividends, if any, are not anticipated to be credited before the later of the later of (a) the Policy Anniversary Date after the Insured attains sixty-five (65) years of age, or (b) the tenth (10th) Policy Anniversary Date.

Nonforfeiture Benefits

If You choose not to select the following optional nonforfeiture rider, a contingent benefit upon lapse will be available if: (a) the Policy lapses as described under the Grace Period and Unintentional Lapse provisions of the Policy; and (b) the premium rates for the Policy are substantially increased. The benefit provided will be in the form of a Shortened Benefit Period as described below.

In addition to the contingent nonforfeiture benefit described above, if You select a limited premium payment option an additional contingent nonforfeiture benefit may also be available in the form of a reduced "paid-up" policy.

OPTIONAL RIDERS (available for an additional premium payment)

Shortened Benefit Period Nonforfeiture

The rider provides a benefit when the Policy lapses, after being in force for at least three (3) years, due to the non-payment of premium. The Policy will become paid-up with modified coverage based on the Daily Benefit Amount in effect immediately prior to the date of lapse. The Total Benefit Amount payable under the rider will be reduced to the greater of: (a) the total of all premiums paid prior to the date of lapse for the Policy and all riders or (b) thirty (30) times the Daily Benefit Amount in effect immediately prior to the date of lapse of the Policy.

Full Return of Premium on Death

If the Insured dies while the Policy is in force, We will pay to Your Beneficiary a benefit equal to the total of all earned premiums paid for the Policy and all attached riders. In the event You have not designated a Beneficiary, this amount will be paid to You, if living, or to Your estate. Upon death of the Insured, We will refund any unearned premium for the Policy on a pro-rata basis.

Return of Premium on Death

If the Insured dies while the Policy is in force, We will pay to Your Beneficiary a benefit equal to the total of all earned premiums paid for the Policy and all attached riders, less all benefits paid under the Policy. In the event You have not designated a Beneficiary, this amount will be paid to You, if living, or to Your estate. Upon death of the Insured, We will refund any unearned premium for the Policy on a pro-rata basis.

Waiver of Premium for Covered Partner

The rider will waive the premium payments for the Policy to which the rider is attached during any period in which the premium payments for the Covered Partner's policy are waived. A Waiver of Premium for Covered Partner must be issued with and remain attached to the Covered Partner's policy. Both the Policy, including the rider and the Covered Partner's policy, including the rider, must remain in force. If both policies or the rider do not remain in force, the rider will terminate and the premium for the rider will end.

Restoration of Benefits

The rider will restore the Total Benefit Amount selected to its original amount and then adjust for the effects of an inflation protection rider, if any, attached to the Policy, if We pay benefits under the Policy and the Insured subsequently

Recovers. Under the rider, Recovers means that the Insured has not exhausted the Total Benefit Amount and for a period of one hundred eighty (180) consecutive days prior to the date the benefits are restored the following three (3) conditions are satisfied: (a) the Policy is in force and premiums are not waived; (b) the Insured is no longer Chronically Ill; and (c) We have not paid benefits under the Policy during the one hundred eighty (180) consecutive days. Benefits may be restored more than once. However, the rider will terminate and the premium for the rider will no longer be due when the total of all amounts, adjusted for the effects of an inflation protection rider, if any, attached to the Policy, restored over the lifetime of the rider is equal to the original Total Benefit Amount. The rider will terminate when the Total Benefit Amount of the Policy is exhausted. In the event You cancel or the Policy lapses due to non-payment of premium, the rider will also terminate.

Paid-Up Survivor Benefit

The rider provides that the Policy to which the rider is attached will be paid-up and no further premium payments required after both of the following have occurred: (a) the tenth (10th) Policy Anniversary Date; and (b) the date of the Covered Partner's death. If the Covered Partner dies before the tenth (10th) Policy Anniversary Date, the premium for the Policy must continue to be paid, including the rider, until the tenth (10th) Policy Anniversary Date, unless waived under the Policy, at which point the Policy will be paid-up and no further premium payments will be required. A Paid-Up Survivor Benefit Rider must be issued with and remain attached to the Covered Partner's policy. Both the Policy, including the rider and the Covered Partner's policy, including the rider, must remain in force. If both policies, or the rider do not remain in force, the rider will terminate and the premium for the rider will end. In the event You cancel or the Policy lapses due to non-payment of premium, the rider will terminate.

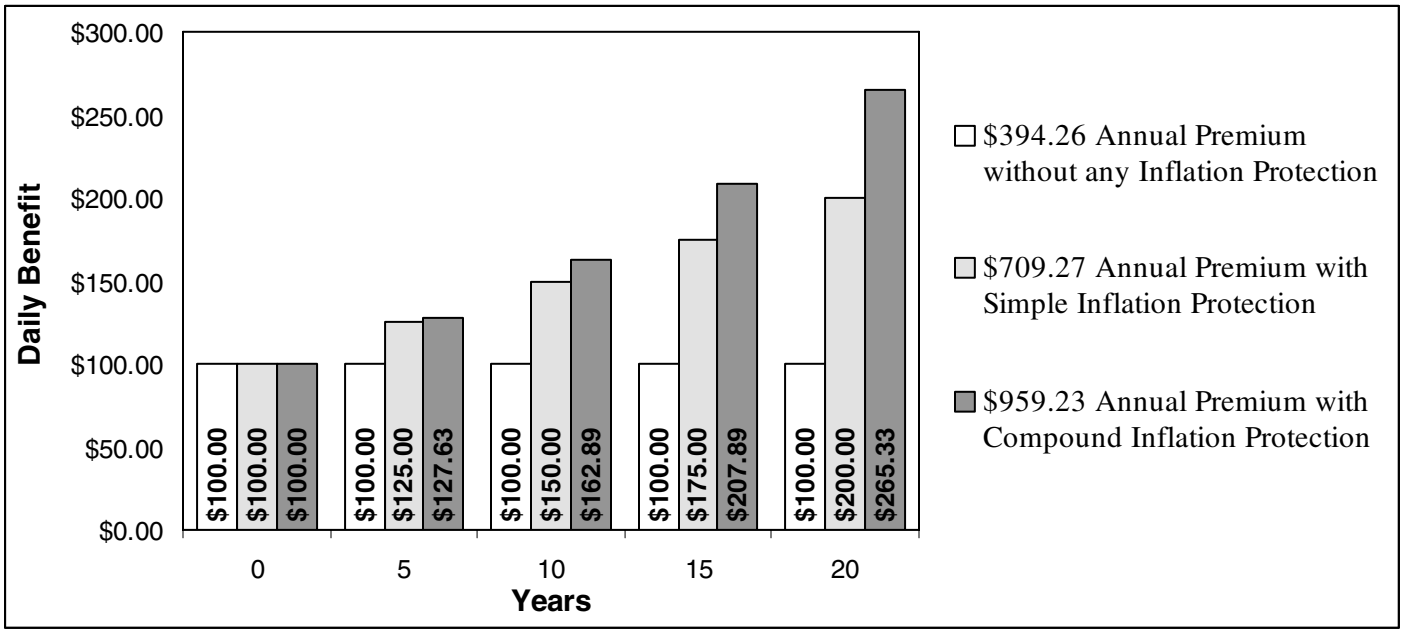
Shared Care Rider

The rider provides for a Shared Total Benefit Amount for Covered Partners in the event that the Total Benefit Amount for the Policy has been exhausted, the Policy will remain in force and We may continue to pay benefits in accordance with the provisions of the Policy until the Shared Total Benefit Amount has also been exhausted. The Policy will terminate on the date that both the Total Benefit Amount and the Shared Benefit Amount are exhausted. The Shared Benefit Amount will be reduced by benefits paid under the Policy and by benefits paid under the Shared Care Rider attached to the Covered Partner's policy. The Shared Benefit Amount will be increased in accordance with any inflation protection rider attached to the Policy. If the Covered Partner dies, the Shared Total Benefit Amount will remain available for as long as the Policy including the rider remain in force. The Policy and the Covered Partner's policy must be identical at the time of purchase and remain in force as identical policies (policy form, Total Benefit Amount, Elimination Period, Daily Benefit Amount, and all attached riders and endorsements). If identical policies do not remain in force, the rider will terminate and the premium for the rider with end. In the event the Policy lapses due to non-payment of premium, the rider will terminate.

Inflation Protection

These riders provide that on each Policy Anniversary Date, while the Policy to which the riders are attached remains in force, including while We are paying benefits, We will increase the Daily Benefits. The Compound Inflation Protection Rider increases the Daily Benefit Amount and Total Benefit Amount in effect immediately prior to the Policy Anniversary Date by five percent (5%). The Simple Inflation Protection Rider increases the Daily Benefit Amount in effect immediately prior to the Policy Anniversary Date by five percent (5%) of the original Daily Benefit Amount in effect at the time the Policy was issued and the Total Benefit Amount by an amount equal to the proportional increase in the Daily Benefit Amount.

The following graph compares the benefits and premiums between a policy with the Compound Inflation Protection Rider, a policy with the Simple Inflation Protection Rider and a policy without either rider. For purposes of illustration, the sample shown is for a policy with a 1,095-day (3-Year) Benefit Period for Facility Services, issued at age fifty-five (55), a ninety (90) day Elimination Period, and a one hundred dollar ($100.00) Daily Benefit Amount.



Agent

Address

Phone Number

CONTACT THE STATE SENIOR HEALTH INSURANCE ASSISTANCE PROGRAM IF YOU HAVE GENERAL QUESTIONS REGARDING LONG TERM CARE INSURANCE. CONTACT THE INSURANCE COMPANY IF YOU HAVE SPECIFIC QUESTIONS REGARDING YOUR LONG TERM CARE INSURANCE POLICY.

Massachusetts Mutual Life Insurance Company
Home Office: Springfield, MA 01111-0001
Long Term Care Administrative Office
P.O. Box 4243
Woodland Hills, CA 91365-4243
888.505.8952

APPLICATION FOR LONG TERM CARE INSURANCE

MM500-A-1-AR (PLEASE PRINT)

Coverage Type:
☐ Individual
☒ Covered Partners (if you select this box you should complete MMD-APB, Covered Partner's or Partner's Benefits Disclosure)
If Covered Partners, relationship to Proposed Applicant 1: Wife

Part 1: Proposed Applicant(s) Information

Proposed Applicant 1	**Proposed Applicant 2**
Name: John B. Doe (First / Middle Initial / Last)	Name: Mary J. Doe (First / Middle Initial / Last)
Social Security Number: 123-45-6789	Social Security Number: 234-56-7891
Date of Birth: 1-1-52 (Month / Day / Year)	Date of Birth: 1-1-57 (Month / Day / Year)
Insuring Age (as of nearest birthday): 55	Insuring Age (as of nearest birthday): 50
Birthplace: Anytown, ST (City / State)	Birthplace: Anytown, ST (City / State)
☒ Male ☐ Female	☐ Male ☒ Female
Home Phone: (555) 555-1212	Home Phone: (555) 555-1212
Work Phone: (555) 555-1212	Work Phone: (555) 555-1212
Cellular Phone: (555) 555-1212	Cellular Phone: (555) 555-1212
Best number to call: Home	Best number to call: Home
Best time to call: 7:00 ☐ A.M. ☒ P.M. ☐ Sat/Sun	Best time to call: 7:00 ☐ A.M. ☒ P.M. ☐ Sat/Sun
E-mail Address: johndoe@email.com	E-mail Address: janedoe@email.com
Occupation:	Occupation:
If retired, date of retirement:	If retired, date of retirement:
Home Address: 123 Main St., Anytown, ST 12345-1234 (City / State / Zip Code)	Home Address: 123 Main St., Anytown, ST 12345-1234 (City / State / Zip Code)
Billing Address (if other than home address above): 123 Main St., Anytown, ST 12345-1234 (City / State / Zip Code)	Billing Address (if other than home address above): 123 Main St., Anytown, ST 12345-1234 (City / State / Zip Code)

Part 2: Coverage & Premium Information

Proposed Applicant 1	Proposed Applicant 2

** If a PARTNERSHIP POLICY is selected below and you are age **60 or younger**, Compound Inflation Protection must be selected and will be issued with your policy. If you are age **61-75**, either Compound or Simple Inflation Protection must be selected and will be issued with your policy.*

1. Basic Plan Selection

- [X] Partnership Policy
- [ ] Non-Partnership Policy
- [ ] Facility Services Only
- [X] Comprehensive – **Facility Services and Home & Community Based Services (HCBS)**
- [ ] Comprehensive with Indemnity Benefit Rider
- [ ] Comprehensive with HCBS Monthly Benefit Rider

2. Daily Benefit $ 100.00

3. Benefit Period:

- [ ] Lifetime
- [ ] 10 Years
- [ ] 6 Years
- [ ] 5 Years
- [ ] 4 Years
- [X] 3 Years
- [ ] 2 Years

4. Elimination Period:

- [ ] 30 Days
- [ ] 60 Days
- [X] 90 Days
- [ ] 180 Days

5. Riders:

** Please refer to Partnership Policy requirements above.*

A. Inflation Protection (may select only one)

- [X] Compound Inflation Protection
- [ ] Simple Inflation Protection

B. Return of Premium (may select only one)

- [ ] Full Return of Premium on Death *(available to age 65)*
- [ ] Return of Premium on Death

Beneficiary Name:

First Middle Initial Last

Relationship: _____

(Designation of Beneficiary is applicable only in conjunction with the purchase of the Return of Premium on Death or the Full Return of Premium on Death Riders.)

C. Elimination Period (may select only one) (not available with Facility Services Only coverage)

- [ ] HCBS Waiver of Elimination Period
- [ ] Enhanced Elimination Period

D. Other Riders

- [X] Shortened Benefit Period Nonforfeiture
- [ ] Restoration of Benefits *(not available with Lifetime Benefit Period)*

(If applying as Covered Partners, both must select any of the following riders)

- [X] Waiver of Premium for Covered Partner
- [ ] Paid-Up Survivor *(available only with Lifetime Premium Payment Option)*
- [ ] Shared Care **(Covered Partner coverage must be identical)** *(not available with Lifetime Benefit Period)*

1. Basic Plan Selection

- [X] Partnership Policy
- [ ] Non-Partnership Policy
- [ ] Facility Services Only
- [X] Comprehensive – **Facility Services and Home & Community Based Services (HCBS)**
- [ ] Comprehensive with Indemnity Benefit Rider
- [ ] Comprehensive with HCBS Monthly Benefit Rider

2. Daily Benefit $ 100.00

3. Benefit Period:

- [ ] Lifetime
- [ ] 10 Years
- [ ] 6 Years
- [ ] 5 Years
- [ ] 4 Years
- [X] 3 Years
- [ ] 2 Years

4. Elimination Period:

- [ ] 30 Days
- [ ] 60 Days
- [X] 90 Days
- [ ] 180 Days

5. Riders:

** Please refer to Partnership Policy requirements above.*

A. Inflation Protection (may select only one)

- [X] Compound Inflation Protection
- [ ] Simple Inflation Protection

B. Return of Premium (may select only one)

- [ ] Full Return of Premium on Death *(available to age 65)*
- [ ] Return of Premium on Death

Beneficiary Name:

First Middle Initial Last

Relationship: _____

(Designation of Beneficiary is applicable only in conjunction with the purchase of the Return of Premium on Death or the Full Return of Premium on Death Riders.)

C. Elimination Period (may select only one) (not available with Facility Services Only coverage)

- [ ] HCBS Waiver of Elimination Period
- [ ] Enhanced Elimination Period

D. Other Riders

- [X] Shortened Benefit Period Nonforfeiture
- [ ] Restoration of Benefits *(not available with Lifetime Benefit Period)*

(If applying as Covered Partners, both must select any of the following riders)

- [X] Waiver of Premium for Covered Partner
- [ ] Paid-Up Survivor *(available only with Lifetime Premium Payment Option)*
- [ ] Shared Care **(Covered Partner coverage must be identical)** *(not available with Lifetime Benefit Period)*

Part 2: Coverage & Premium Information (continued)

6. Rate Class

☐ Ultra Preferred ☒ Select Preferred ☐ Preferred

7. Discounts (see Application Instructions)

☒ Covered Partner Discount (2 Proposed Applicants)
☐ Partner Discount (1 Proposed Applicant)
☐ Loyal Customer Discount

Policy Number: _____

☐ Employer/Association Group Discount
Group Identification Name and Number

_____
Name Number

8. Premium Information

Direct Payment Mode:
☒ Annually ☐ Semi-Annually ☐ Quarterly ☐ PAC

☐ List Billing
☐ Annually ☐ Semi-Annually ☐ Quarterly ☐ Monthly

9. Premium Payment Options (select only one)

☐ Lifetime
☒ 10 Pay
☐ Paid-Up at 65 *(available to age 55)*
(Limited Premium Payment Options are not available under age 40)

Premium Payment (may select only one)

☒ Standard
☐ Discounted Renewals *(available only with Lifetime Premium Payment Option)*

First Year: $_____

Renewal: $_____

Initial Premium Paid with Application $ 2434.86

Special Request/Requested Effective Date

_____

_____

6. Rate Class

☐ Ultra Preferred ☒ Select Preferred ☐ Preferred

7. Discounts (see Application Instructions)

☒ Covered Partner Discount (2 Proposed Applicants)
☐ Partner Discount (1 Proposed Applicant)
☐ Loyal Customer Discount

Policy Number: _____

☐ Employer/Association Group Discount
Group Identification Name and Number

_____
Name Number

8. Premium Information

Direct Payment Mode:
☒ Annually ☐ Semi-Annually ☐ Quarterly ☐ PAC

☐ List Billing
☐ Annually ☐ Semi-Annually ☐ Quarterly ☐ Monthly

9. Premium Payment Options (select only one)

☐ Lifetime
☒ 10 Pay
☐ Paid-Up at 65 *(available to age 55)*
(Limited Premium Payment Options are not available under age 40)

Premium Payment (may select only one)

☒ Standard
☐ Discounted Renewals *(available only with Lifetime Premium Payment Option)*

First Year: $_____

Renewal: $_____

Initial Premium Paid with Application $ 2000.00

Special Request/Requested Effective Date

_____

_____

* *See page 2 of this Application for Inflation Protection requirements related to* ***Partnership Policies****.*

REJECTION OF INFLATION PROTECTION RIDERS — I have reviewed the Outline of Coverage and the graph that compares the benefits and premiums of this policy with and without the Inflation Protection Riders and I have chosen to reject these riders.
Check here: ☐

REJECTION OF NONFORFEITURE RIDER — I have reviewed the Outline of Coverage that describes the Shortened Benefit Period Nonforfeiture Rider and I have chosen to reject the rider.
Check here: ☐

REJECTION OF INFLATION PROTECTION RIDERS — I have reviewed the Outline of Coverage and the graph that compares the benefits and premiums of this policy with and without the Inflation Protection Riders and I have chosen to reject these riders.
Check here: ☐

REJECTION OF NONFORFEITURE RIDER — I have reviewed the Outline of Coverage that describes the Shortened Benefit Period Nonforfeiture Rider and I have chosen to reject the rider.
Check here: ☐

Part 3: Insurability Information

Proposed Applicant 1	Proposed Applicant 2
3A. Do you currently need assistance with bathing, dressing, eating, taking medication, transferring from bed to chair, or toileting? ☐ yes ☒ no	3A. Do you currently need assistance with bathing, dressing, eating, taking medication, transferring from bed to chair, or toileting? ☐ yes ☒ no
3B. During the past 10 years, have you been medically diagnosed or treated for any of the following:	3B. During the past 10 years, have you been medically diagnosed or treated for any of the following:
☐ yes ☒ no AIDS or positive HIV status	☐ yes ☒ no AIDS or positive HIV status
☐ yes ☒ no Alzheimer's Disease	☐ yes ☒ no Alzheimer's Disease
☐ yes ☒ no Amyotrophic Lateral Sclerosis/Lou Gehrig's Disease	☐ yes ☒ no Amyotrophic Lateral Sclerosis/Lou Gehrig's Disease
☐ yes ☒ no Cerebral Palsy	☐ yes ☒ no Cerebral Palsy
☐ yes ☒ no Cystic Fibrosis	☐ yes ☒ no Cystic Fibrosis
☐ yes ☒ no Dementia	☐ yes ☒ no Dementia
☐ yes ☒ no Hepatitis-Chronic	☐ yes ☒ no Hepatitis-Chronic
☐ yes ☒ no Huntington's Chorea	☐ yes ☒ no Huntington's Chorea
☐ yes ☒ no Insulin Dependent Diabetes	☐ yes ☒ no Insulin Dependent Diabetes
☐ yes ☒ no Kidney Disease requiring dialysis	☐ yes ☒ no Kidney Disease requiring dialysis
☐ yes ☒ no Liver Cirrhosis	☐ yes ☒ no Liver Cirrhosis
☐ yes ☒ no Multiple Sclerosis	☐ yes ☒ no Multiple Sclerosis
☐ yes ☒ no Myasthenia Gravis	☐ yes ☒ no Myasthenia Gravis
☐ yes ☒ no Organic Brain Syndrome	☐ yes ☒ no Organic Brain Syndrome
☐ yes ☒ no Paralysis	☐ yes ☒ no Paralysis
☐ yes ☒ no Parkinson's/Parkinsonism	☐ yes ☒ no Parkinson's/Parkinsonism
☐ yes ☒ no Stroke	☐ yes ☒ no Stroke
☐ yes ☒ no TIA	☐ yes ☒ no TIA
☐ yes ☒ no Schizophrenia	☐ yes ☒ no Schizophrenia
☐ yes ☒ no Systemic Lupus	☐ yes ☒ no Systemic Lupus

PLEASE NOTE BEFORE YOU CONTINUE WITH THIS APPLICATION: If you answered YES to any question in Part 3, we suggest that you do not submit the application. If you answered NO to every question, please continue.

Part 4: Medical Information

Proposed Applicant 1	Proposed Applicant 2
4A. Are you currently receiving Social Security Disability or Medicaid (not Medicare)? ☐ yes ☒ no	4A. Are you currently receiving Social Security Disability or Medicaid (not Medicare)? ☐ yes ☒ no
4B. Do you currently use or have you used in the past 12 months a walker, crutches, braces, wheelchair, motorized cart, hospital bed, oxygen, or cane? ☐ yes ☒ no	4B. Do you currently use or have you used in the past 12 months a walker, crutches, braces, wheelchair, motorized cart, hospital bed, oxygen, or cane? ☐ yes ☒ no
4C. Within the past 12 months have you been advised to have any special testing or surgery that has not yet been performed or are you aware of any symptoms or complaints for which you plan to seek medical advice or treatment? ☐ yes ☒ no	4C. Within the past 12 months have you been advised to have any special testing or surgery that has not yet been performed or are you aware of any symptoms or complaints for which you plan to seek medical advice or treatment? ☐ yes ☒ no

Part 4: Medical Information (continued)

4D. Within the past 12 months, have you received rehabilitative services including physical therapy, occupational therapy, home care or been confined to a nursing home or assisted living facility? ☐ yes ☒ no	4D. Within the past 12 months, have you received rehabilitative services including physical therapy, occupational therapy, home care or been confined to a nursing home or assisted living facility? ☐ yes ☒ no
4E. Within the past 12 months, have you received disability income or workers' compensation or any other state disability? ☐ yes ☒ no	4E. Within the past 12 months, have you received disability income or workers' compensation or any other state disability? ☐ yes ☒ no
4F. Within the past 5 years, have you had or been issued a handicap tag? ☐ yes ☒ no	4F. Within the past 5 years, have you had or been issued a handicap tag? ☐ yes ☒ no
4G. Within the past 5 years, have you been declined for long term care insurance? ☐ yes ☒ no	4G. Within the past 5 years, have you been declined for long term care insurance? ☐ yes ☒ no
4H. During the past 10 years, have you received medical advice, consultation, or treatment for the following conditions? ☐ yes ☒ no Alcoholism, Drug Dependency ☐ yes ☒ no Blood or Endocrine (Glandular) Disorder ☐ yes ☒ no High Blood Pressure ☐ yes ☒ no Diabetes ☐ yes ☒ no Brain, Spinal Cord, or Neurological Disease ☐ yes ☒ no Cancer (Internal) ☐ yes ☒ no Heart, Circulatory, Vascular Disorder ☐ yes ☒ no Kidney, Bladder, or Prostate Condition ☐ yes ☒ no Musculoskeletal (bone or joint) or Skin Disorder ☐ yes ☒ no Progressive Eye Condition ☐ yes ☒ no Psychiatric, Mental Disorder, or Depression ☐ yes ☒ no Respiratory or Lung Disorder ☐ yes ☒ no Stomach, Esophagus, Intestine, Liver, or Pancreas Condition	4H. During the past 10 years, have you received medical advice, consultation, or treatment for the following conditions? ☐ yes ☒ no Alcoholism, Drug Dependency ☐ yes ☒ no Blood or Endocrine (Glandular) Disorder ☐ yes ☒ no High Blood Pressure ☐ yes ☒ no Diabetes ☐ yes ☒ no Brain, Spinal Cord, or Neurological Disease ☐ yes ☒ no Cancer (Internal) ☐ yes ☒ no Heart, Circulatory, Vascular Disorder ☐ yes ☒ no Kidney, Bladder, or Prostate Condition ☐ yes ☒ no Musculoskeletal (bone or joint) or Skin Disorder ☐ yes ☒ no Progressive Eye Condition ☐ yes ☒ no Psychiatric, Mental Disorder, or Depression ☐ yes ☒ no Respiratory or Lung Disorder ☐ yes ☒ no Stomach, Esophagus, Intestine, Liver, or Pancreas Condition
4I. What is your current Weight: 180 Height: 6' 0" 4J. Any changes in weight of 15 pounds or more within past 12 months? ☐ yes ☒ no If YES answer above indicate gain or loss and reason: _____ 4K. Have you smoked cigarettes in past 12 months: ☐ yes ☒ no If quit, date last smoked? _____	4I. What is your current Weight: 180 Height: 6' 0" 4J. Any changes in weight of 15 pounds or more within past 12 months? ☐ yes ☒ no If YES answer above indicate gain or loss and reason: _____ 4K. Have you smoked cigarettes in past 12 months: ☐ yes ☒ no If quit, date last smoked? _____

Part 5: DETAILS Section

If you answer YES to any question in Part 4A-H, please give full details of illness, injury, symptoms, duration, treatment and results:

Proposed Applicant 1	**Proposed Applicant 2**
Question#	Question#
Condition/Diagnosis	Condition/Diagnosis
Date of Diagnosis or Onset	Date of Diagnosis or Onset
Treatment Date(s)	Treatment Date(s)
Treating Medical Professional/Facility Name/Address/City/State/Telephone#	Treating Medical Professional/Facility Name/Address/City/State/Telephone#
Question#	Question#
Condition/Diagnosis	Condition/Diagnosis
Date of Diagnosis or Onset	Date of Diagnosis or Onset
Treatment Date(s)	Treatment Date(s)
Treating Medical Professional/Facility Name/Address/City/State/Telephone#	Treating Medical Professional/Facility Name/Address/City/State/Telephone#

If necessary, please use the space below for any additional details

Part 6: Physician and Medication Section

A. Primary Care Physician (PCP) and other Physicians consulted within past 5 years:

Proposed Applicant 1	Proposed Applicant 2
PCP (current) or MD who has most complete records of your medical history. If you changed your doctor in the past 12 months, please provide previous doctor's information. Name: J. Doctor Address: 145 Main St. City: Anytown State: ST 12345-1234 Date/Reason of last office visit: 1-1-06 Check-up	PCP (current) or MD who has most complete records of your medical history. If you changed your doctor in the past 12 months, please provide previous doctor's information. Name: J. Doctor Address: 145 Main St. City: Anytown State: ST 12345-1234 Date/Reason of last office visit: 1-1-06 Check-up
Other Physicians (Indicate Specialty, Address/City/State/ Phone# /Date & Reason Consulted):	Other Physicians (Indicate Specialty, Address/City/State/ Phone# /Date & Reason Consulted):

B. Medications: List all prescription medications taken at any time over the past 12 months:

Proposed Applicant 1	Proposed Applicant 2
Medication/Dosage/Frequency/Reason/MD Prescribed	Medication/Dosage/Frequency/Reason/MD Prescribed
Medication/Dosage/Frequency/Reason/MD Prescribed	Medication/Dosage/Frequency/Reason/MD Prescribed
Medication/Dosage/Frequency/Reason/MD Prescribed	Medication/Dosage/Frequency/Reason/MD Prescribed
Medication/Dosage/Frequency/Reason/MD Prescribed	Medication/Dosage/Frequency/Reason/MD Prescribed

Part 7: Information about your Insurance Coverage

Proposed Applicant 1	Proposed Applicant 2
1. Do you have a policy, certificate or application with this or any other company providing long term care insurance (including health care service contract or health maintenance organization contract)? ☐ yes ☒ no	1. Do you have a policy, certificate or application with this or any other company providing long term care insurance (including health care service contract or health maintenance organization contract)? ☐ yes ☒ no
2. Did you have another long term care insurance policy or certificate in force during the past 12 months? ☐ yes ☒ no If that policy lapsed, provide date of lapse: __________	2. Did you have another long term care insurance policy or certificate in force during the past 12 months? ☐ yes ☒ no If that policy lapsed, provide date of lapse: __________
3. Do you intend to replace any of your long term care, medical or health insurance coverage with this policy? ☐ yes ☒ no	3. Do you intend to replace any of your long term care, medical or health insurance coverage with this policy? ☐ yes ☒ no
If you answered YES to any of Questions 1-3 provide full details below and complete required replacement forms:	If you answered YES to any of Questions 1-3 provide full details below and complete required replacement forms:
Question #: ____ Company: ____ Issue Date: ____ Type: ____ Daily Benefit: ____ Paid to date: ____	Question #: ____ Company: ____ Issue Date: ____ Type: ____ Daily Benefit: ____ Paid to date: ____
Question #: ____ Company: ____ Issue Date: ____ Type: ____ Daily Benefit: ____ Paid to date: ____	Question #: ____ Company: ____ Issue Date: ____ Type: ____ Daily Benefit: ____ Paid to date: ____
Question #: ____ Company: ____ Issue Date: ____ Type: ____ Daily Benefit: ____ Paid to date: ____	Question #: ____ Company: ____ Issue Date: ____ Type: ____ Daily Benefit: ____ Paid to date: ____

Part 8: Protection Against Unintentional Lapse

I understand that I have the right to designate at least one person other than myself to receive notice of lapse or termination of this long term care insurance policy for non-payment of premium. I understand that notice will not be given until thirty (30) days after a premium is due and unpaid. **Check applicable box:**

Proposed Applicant 1	Proposed Applicant 2
☒ I elect NOT to designate any person to receive such notice	☒ I elect NOT to designate any person to receive such notice
☐ I designate the following person to receive notice prior to cancellation of my policy for non-payment of premium:	☐ I designate the following person to receive notice prior to cancellation of my policy for non-payment of premium:
Name:____ Telephone #:____ Address:____ Relationship:____	Name:____ Telephone #:____ Address:____ Relationship:____

Part 9: Proposed Applicant Statements

NOTICE OF INSURANCE INFORMATION PRACTICES - To evaluate your application, we will need some personal information about you. It may be necessary to obtain some of that information from sources other than yourself. For your protection, you have a qualified right to learn what information we obtain about you. You also have the right to request correction of any erroneous information. The information we obtain about you will be used by Massachusetts Mutual Life Insurance Company to determine eligibility for insurance and/or benefits under an existing policy and for other business purposes in connection with the insurance relationship. The information obtained may not be released to any person or organization except to reinsuring companies, any third party administrators designated by Massachusetts Mutual Life Insurance Company or other persons or organizations performing services in connection with your application, claim or as may be otherwise lawfully required or as you may further authorize. We will furnish a more detailed summary of our information practices upon request.

AGREEMENT — The answers given are complete and true to the best of my knowledge and belief. I understand that the Company will rely on my written answers to the questions in this application and that if my answers are not complete and true, my policy may not be valid. I also understand that the agent cannot determine eligibility for or alter the terms of the proposed policy.

ACKNOWLEDGMENT — I acknowledge receipt of an Outline of Coverage, NAIC Shopper's Guide, Potential Rate Increase Disclosure Form, Conditional Premium Receipt Information and Notice of Privacy Practices.

This application in totality will be part of the insurance policy for which I am applying. Further, if this application has been completed by two Proposed Applicants I understand that a copy of this application will be included in my Covered Partner's policy.

"I", "you", and "your" mean the Proposed Applicant 1 and if applicable, Proposed Applicant 2 applying for coverage under this application.

CAUTION: If your answers on this application are incorrect or untrue, Massachusetts Mutual Life Insurance Company may have the right to deny benefits or rescind your policy.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Signed at Anytown, ST (City) (State) ON 1-1-07 (Date)

Signature of Proposed Applicant 1: John Doe

Signed at Anytown, ST (City) (State) ON 1-1-07 (Date)

Signature of Proposed Applicant 2: Mary Doe

Part 10: Agent Statement

Yes	No		
☐	☒	1.	**To the best of your knowledge, is the insurance applied for intended to replace any long term care, medical or health insurance in force with this or any other company?**
		2.	**List any other health insurance policies that you have sold to the Proposed Applicant(s):**
			(a) Which of the policies listed above are still in force, if any?
			(b) Which of the policies listed above sold in the past 5 years are no longer in force, if any?
☒	☐	3.	**Did you ask the Proposed Applicant(s) all the questions face to face and witness their signature(s)?**
			If "No," provide details:
☒	☐	4.	**Did you deliver to the Proposed Applicant(s) the Outline of Coverage, the required Disclosures, the NAIC Shopper's Guide and the Notice of Privacy Practices?**

I certify that the answers to the questions provided by the Proposed Applicant(s) were fully and accurately recorded in the application, and that the questions in the Agent's Statement have been answered accurately. I have reviewed the current health insurance coverage of the Proposed Applicant(s) and find that the coverage of the type and amount applied for is appropriate for the needs of the Proposed Applicant(s). Further, if this is a replacement, I have reviewed the current health insurance coverage of the Proposed Applicant(s) and find that this replacement is appropriate for the needs of the Proposed Applicant(s).

John Q. Porter	1234	John Q. Porter	1-1-07
Licensed Agent's Name (please print)	Ident. Code	Licensed Agent's Signature	Date

(555) 555-1515	(555) 555-1414	5678
Agent's Phone	Agent's Fax	Agency Number

Massachusetts Mutual Life Insurance Company
Home Office: Springfield, MA 01111-0001
Long Term Care Administrative Office
P.O. Box 4243
Woodland Hills, CA 91365-4243
888.505.8952

APPLICATION FOR
LONG TERM CARE INSURANCE
MM500-SA-1-1-AR Part 1 (PLEASE PRINT)

Coverage Type:
☐ Individual
☒ Covered Partners (if you select this box you should complete MMD-APB, Covered Partner's or Partner's Benefits Disclosure)
If Covered Partners, relationship to Proposed Applicant 1: Wife

Section 1: Proposed Applicant(s) Information

Proposed Applicant 1	**Proposed Applicant 2**
Name: John B. Doe (First / Middle Initial / Last)	Name: Mary J. Doe (First / Middle Initial / Last)
Social Security Number: 123-45-6789	Social Security Number: 234-56-7891
Date of Birth: 1-1-52 (Month / Day / Year)	Date of Birth: 1-1-57 (Month / Day / Year)
Insuring Age (as of nearest birthday): 55	Insuring Age (as of nearest birthday): 50
Birthplace: Anytown, ST (City / State)	Birthplace: Anytown, ST (City / State)
☒ Male ☐ Female	☐ Male ☒ Female
Home Phone: (555) 555-1212	Home Phone: (555) 555-1212
Work Phone: (555) 555-1212	Work Phone: (555) 555-1212
Cellular Phone: (555) 555-1212	Cellular Phone: (555) 555-1212
Best number to call: Home	Best number to call: Home
Best time to call: 7:00 ☐ A.M. ☒ P.M. ☐ Sat/Sun	Best time to call: 7:00 ☐ A.M. ☒ P.M. ☐ Sat/Sun
E-mail Address: johndoe@email.com	E-mail Address: janedoe@email.com
Occupation:	Occupation:
	If retired, date of retirement:
Home Address: 123 Main St., Anytown, ST 12345-1234 (City / State / Zip Code)	Home Address: 123 Main St., Anytown, ST 12345-1234 (City / State / Zip Code)
Billing Address (if other than home address above): 123 Main St., Anytown, ST 12345-1234 (City / State / Zip Code)	Billing Address (if other than home address above): 123 Main St., Anytown, ST 12345-1234 (City / State / Zip Code)

Section 2: Coverage & Premium Information

Proposed Applicant 1	Proposed Applicant 2

** If a PARTNERSHIP POLICY is selected below and you are age **60 or younger**, Compound Inflation Protection must be selected and will be issued with your policy. If you are age **61-75**, either Compound or Simple Inflation Protection must be selected and will be issued with your policy.*

1. Basic Plan Selection

- [X] Partnership Policy
- [ ] Non-Partnership Policy
- [ ] Facility Services Only
- [X] Comprehensive – **Facility Services and Home & Community Based Services (HCBS)**
- [ ] Comprehensive with Indemnity Benefit Rider
- [ ] Comprehensive with HCBS Monthly Benefit Rider

2. Daily Benefit $ 100.00

3. Benefit Period:

- [ ] Lifetime
- [ ] 10 Years
- [ ] 6 Years
- [ ] 5 Years
- [ ] 4 Years
- [X] 3 Years
- [ ] 2 Years

4. Elimination Period:

- [ ] 30 Days
- [ ] 60 Days
- [X] 90 Days
- [ ] 180 Days

5. Riders:

** Please refer to Partnership Policy requirements above.*

A. Inflation Protection (may select only one)

- [X] Compound Inflation Protection
- [ ] Simple Inflation Protection

B. Return of Premium (may select only one)

- [ ] Full Return of Premium on Death *(available to age 65)*
- [ ] Return of Premium on Death

Beneficiary Name:

First Middle Initial Last

Relationship: _____

(Designation of Beneficiary is applicable only in conjunction with the purchase of the Return of Premium on Death or the Full Return of Premium on Death Riders.)

C. Elimination Period (may select only one) (not available with Facility Services Only coverage)

- [ ] HCBS Waiver of Elimination Period
- [ ] Enhanced Elimination Period

D. Other Riders

- [X] Shortened Benefit Period Nonforfeiture
- [ ] Restoration of Benefits *(not available with Lifetime Benefit Period)*

(If applying as Covered Partners, both must select any of the following riders)

- [X] Waiver of Premium for Covered Partner
- [ ] Paid-Up Survivor *(available only with Lifetime Premium Payment Option)*
- [ ] Shared Care **(Covered Partner coverage must be identical)** *(not available with Lifetime Benefit Period)*

1. Basic Plan Selection

- [X] Partnership Policy
- [ ] Non-Partnership Policy
- [ ] Facility Services Only
- [X] Comprehensive – **Facility Services and Home & Community Based Services (HCBS)**
- [ ] Comprehensive with Indemnity Benefit Rider
- [ ] Comprehensive with HCBS Monthly Benefit Rider

2. Daily Benefit $ 100.00

3. Benefit Period:

- [ ] Lifetime
- [ ] 10 Years
- [ ] 6 Years
- [ ] 5 Years
- [ ] 4 Years
- [X] 3 Years
- [ ] 2 Years

4. Elimination Period:

- [ ] 30 Days
- [ ] 60 Days
- [X] 90 Days
- [ ] 180 Days

5. Riders:

** Please refer to Partnership Policy requirements above.*

A. Inflation Protection (may select only one)

- [X] Compound Inflation Protection
- [ ] Simple Inflation Protection

B. Return of Premium (may select only one)

- [ ] Full Return of Premium on Death *(available to age 65)*
- [ ] Return of Premium on Death

Beneficiary Name:

First Middle Initial Last

Relationship: _____

(Designation of Beneficiary is applicable only in conjunction with the purchase of the Return of Premium on Death or the Full Return of Premium on Death Riders.)

C. Elimination Period (may select only one) (not available with Facility Services Only coverage)

- [ ] HCBS Waiver of Elimination Period
- [ ] Enhanced Elimination Period

D. Other Riders

- [X] Shortened Benefit Period Nonforfeiture
- [ ] Restoration of Benefits *(not available with Lifetime Benefit Period)*

(If applying as Covered Partners, both must select any of the following riders)

- [X] Waiver of Premium for Covered Partner
- [ ] Paid-Up Survivor *(available only with Lifetime Premium Payment Option)*
- [ ] Shared Care **(Covered Partner coverage must be identical)** *(not available with Lifetime Benefit Period)*

Section 2: Coverage & Premium Information (continued)

Proposed Applicant 1	Proposed Applicant 2
6. Rate Class ☐ Ultra Preferred ☒ Select Preferred ☐ Preferred	**6. Rate Class** ☐ Ultra Preferred ☒ Select Preferred ☐ Preferred
7. Discounts (see Application Instructions) ☒ Covered Partner Discount (2 Proposed Applicants) ☐ Partner Discount (1 Proposed Applicant) ☐ Loyal Customer Discount Policy Number: _____ ☐ Employer Group Discount Group Identification Name and Number _____ Name Number	**7. Discounts (see Application Instructions)** ☒ Covered Partner Discount (2 Proposed Applicants) ☐ Partner Discount (1 Proposed Applicant) ☐ Loyal Customer Discount Policy Number: _____ ☐ Employer Group Discount Group Identification Name and Number _____ Name Number
8. Premium Information List Billing ☐ Annually ☐ Semi-Annually ☐ Quarterly ☐ Monthly	**8. Premium Information** Direct Payment Mode: ☒ Annually ☐ Semi-Annually ☐ Quarterly ☐ PAC List Billing ☐ Annually ☐ Semi-Annually ☐ Quarterly ☐ Monthly
9. Premium Payment Options (select only one) ☐ Lifetime ☒ 10 Pay ☐ Paid-Up at 65 *(available to age 55)* *(Limited Premium Payment Options are not available under age 40)*	**9. Premium Payment Options (select only one)** ☐ Lifetime ☒ 10 Pay ☐ Paid-Up at 65 *(available to age 55)* *(Limited Premium Payment Options are not available under age 40)*
Premium Payment (may select only one) ☒ Standard ☐ Discounted Renewals *(available only with Lifetime Premium Payment Option)* First Year: $_____ Renewal: $_____	**Premium Payment (may select only one)** ☒ Standard ☐ Discounted Renewals *(available only with Lifetime Premium Payment Option)* First Year: $_____ Renewal: $_____
Special Request/Requested Effective Date _____ _____	**Special Request/Requested Effective Date** _____ _____
** See page 2 of this Application for Inflation Protection requirements related to **Partnership Policies**.*	
REJECTION OF INFLATION PROTECTION RIDERS — I have reviewed the Outline of Coverage and the graph that compares the benefits and premiums of this policy with and without the Inflation Protection Riders and I have chosen to reject these riders. Check here: ☐ **REJECTION OF NONFORFEITURE RIDER** — I have reviewed the Outline of Coverage that describes the Shortened Benefit Period Nonforfeiture Rider and I have chosen to reject the rider. Check here: ☐	**REJECTION OF INFLATION PROTECTION RIDERS** — I have reviewed the Outline of Coverage and the graph that compares the benefits and premiums of this policy with and without the Inflation Protection Riders and I have chosen to reject these riders. Check here: ☐ **REJECTION OF NONFORFEITURE RIDER** — I have reviewed the Outline of Coverage that describes the Shortened Benefit Period Nonforfeiture Rider and I have chosen to reject the rider. Check here: ☐

Section 3: Insurability Information

Proposed Applicant 1	Proposed Applicant 2
1. Do you currently need assistance with bathing, dressing, eating, taking medication, transferring from bed to chair, or toileting? ☐ yes ☒ no	1. Do you currently need assistance with bathing, dressing, eating, taking medication, transferring from bed to chair, or toileting? ☐ yes ☒ no
2. During the past 10 years, have you been medically diagnosed or treated for any of the following:	2. During the past 10 years, have you been medically diagnosed or treated for any of the following:
☐ yes ☒ no AIDS or positive HIV status	☐ yes ☒ no AIDS or positive HIV status
☐ yes ☒ no Alzheimer's Disease	☐ yes ☒ no Alzheimer's Disease
☐ yes ☒ no Amyotrophic Lateral Sclerosis/Lou Gehrig's Disease	☐ yes ☒ no Amyotrophic Lateral Sclerosis/Lou Gehrig's Disease
☐ yes ☒ no Cerebral Palsy	☐ yes ☒ no Cerebral Palsy
☐ yes ☒ no Cystic Fibrosis	☐ yes ☒ no Cystic Fibrosis
☐ yes ☒ no Dementia	☐ yes ☒ no Dementia
☐ yes ☒ no Hepatitis-Chronic	☐ yes ☒ no Hepatitis-Chronic
☐ yes ☒ no Huntington's Chorea	☐ yes ☒ no Huntington's Chorea
☐ yes ☒ no Insulin Dependent Diabetes	☐ yes ☒ no Insulin Dependent Diabetes
☐ yes ☒ no Kidney Disease requiring dialysis	☐ yes ☒ no Kidney Disease requiring dialysis
☐ yes ☒ no Liver Cirrhosis	☐ yes ☒ no Liver Cirrhosis
☐ yes ☒ no Multiple Sclerosis	☐ yes ☒ no Multiple Sclerosis
☐ yes ☒ no Myasthenia Gravis	☐ yes ☒ no Myasthenia Gravis
☐ yes ☒ no Organic Brain Syndrome	☐ yes ☒ no Organic Brain Syndrome
☐ yes ☒ no Paralysis	☐ yes ☒ no Paralysis
☐ yes ☒ no Parkinson's/Parkinsonism	☐ yes ☒ no Parkinson's/Parkinsonism
☐ yes ☒ no Stroke	☐ yes ☒ no Stroke
☐ yes ☒ no TIA	☐ yes ☒ no TIA
☐ yes ☒ no Schizophrenia	☐ yes ☒ no Schizophrenia
☐ yes ☒ no Systemic Lupus	☐ yes ☒ no Systemic Lupus

If you answered YES to any question under Insurability Information above, we suggest that you do not submit the application. If you answered NO to every question, please continue.

Primary Care Physician (PCP) and other Physicians consulted within past 5 years:

Proposed Applicant 1	Proposed Applicant 2
PCP (current) or MD who has most complete records of your medical history. If you changed your doctor in the past 12 months, please provide previous doctor's information. Name: J. Doctor Address: 145 Main St. City: Anytown State: ST 12345-1234 Date/Reason of last office visit: 1-1-06 Check-up	PCP (current) or MD who has most complete records of your medical history. If you changed your doctor in the past 12 months, please provide previous doctor's information. Name: J. Doctor Address: 145 Main St. City: Anytown State: ST 12345-1234 Date/Reason of last office visit: 1-1-06 Check-up
Other Physicians (Indicate Specialty, Address/City/State/ Phone# /Date & Reason Consulted): _____ _____ _____	Other Physicians (Indicate Specialty, Address/City/State/ Phone# /Date & Reason Consulted): _____ _____ _____

Section 4: Information about your Insurance Coverage

Proposed Applicant 1	Proposed Applicant 2
1. Do you have a policy, certificate or application with this or any other company providing long term care insurance (including health care service contract or health maintenance organization contract)? ☐ yes ☒ no	1. Do you have a policy, certificate or application with this or any other company providing long term care insurance (including health care service contract or health maintenance organization contract)? ☐ yes ☒ no
2. Did you have another long term care insurance policy or certificate in force during the past 12 months? ☐ yes ☒ no If that policy lapsed, provide date of lapse: _____	2. Did you have another long term care insurance policy or certificate in force during the past 12 months? ☐ yes ☒ no If that policy lapsed, provide date of lapse: _____
3. Do you intend to replace any of your long term care, medical or health insurance coverage with this policy? ☐ yes ☒ no	3. Do you intend to replace any of your long term care, medical or health insurance coverage with this policy? ☐ yes ☒ no
If you answered YES to any of Questions 1-3 provide full details below and complete required replacement forms: Question #: _____ Company: _____ Issue Date: _____ Type: _____ Daily Benefit: _____ Paid to date: _____	If you answered YES to any of Questions 1-3 provide full details below and complete required replacement forms: Question #: _____ Company: _____ Issue Date: _____ Type: _____ Daily Benefit: _____ Paid to date: _____
Question #: _____ Company: _____ Issue Date: _____ Type: _____ Daily Benefit: _____ Paid to date: _____	Question #: _____ Company: _____ Issue Date: _____ Type: _____ Daily Benefit: _____ Paid to date: _____
Question #: _____ Company: _____ Issue Date: _____ Type: _____ Daily Benefit: _____ Paid to date: _____	Question #: _____ Company: _____ Issue Date: _____ Type: _____ Daily Benefit: _____ Paid to date: _____

Section 5: Protection Against Unintentional Lapse

I understand that I have the right to designate at least one person other than myself to receive notice of lapse or termination of this long term care insurance policy for non-payment of premium. I understand that notice will not be given until thirty (30) days after a premium is due and unpaid. **Check applicable box:**

Proposed Applicant 1	Proposed Applicant 2
☒ I elect NOT to designate any person to receive such notice	☒ I elect NOT to designate any person to receive such notice
☐ I designate the following person to receive notice prior to cancellation of my policy for non-payment of premium:	☐ I designate the following person to receive notice prior to cancellation of my policy for non-payment of premium:
Name:_____	Name:_____
Telephone #:_____	Telephone #:_____
Address:_____	Address:_____
Relationship:_____	Relationship:_____

Section 6: Proposed Applicant Statements

NOTICE OF INSURANCE INFORMATION PRACTICES — To evaluate your application, we will need some personal information about you. It may be necessary to obtain some of that information from sources other than yourself. For your protection, you have a qualified right to learn what information we obtain about you. You also have the right to request correction of any erroneous information. The information we obtain about you will be used by Massachusetts Mutual Life Insurance Company to determine eligibility for insurance and/or benefits under an existing policy and for other business purposes in connection with the insurance relationship. The information obtained may not be released to any person or organization except to reinsuring companies, any third party administrators designated by Massachusetts Mutual Life Insurance Company or other persons or organizations performing services in connection with your application, claim or as may be otherwise lawfully required or as you may further authorize. We will furnish a more detailed summary of our information practices upon request.

AGREEMENT — The answers given on Part 1 of this application and my subsequent responses on Part 2 of the application are complete and true and were correctly recorded to the best of my knowledge and belief. I understand that the Company will rely on my written answers to the questions in Parts 1 and 2 of this application and that if my answers are not complete and true, my policy may not be valid. I understand that the agent cannot determine eligibility for or alter the terms of the proposed policy.

The following applies individually and separately to each Proposed Applicant: I understand that the insurance applied for will become effective and in force on the Policy Effective Date only if all of the following occur: (1) Parts 1 and 2 of this application are approved by the Company; (2) a policy is issued during the lifetime of the Proposed Applicant; (3) the full first premium is paid; and (4) there has been no change in the insurability of the Proposed Applicant since the date of completion of Parts 1 and 2 of the application, and the date the policy is delivered.

ACKNOWLEDGMENT — I acknowledge receipt of an Outline of Coverage, NAIC Shopper's Guide, Potential Rate Increase Disclosure Form and Notice of Privacy Practices.

This application (including Parts 1 and 2) will be part of the insurance policy for which I am applying. Further, if this application has been completed by two Proposed Applicants I understand that a copy of this application will be included in my Covered Partner's policy.

"I", "you", and "your" mean the Proposed Applicant 1 and if applicable, Proposed Applicant 2 applying for coverage under this application.

AUTHORIZATION FOR DISCLOSURE, RECEIPT AND USE OF PERSONAL HEALTH INFORMATION —

☒ Complete and submit F8186 with this application.

CAUTION: If your answers on this application are incorrect or untrue, Massachusetts Mutual Life Insurance Company may have the right to deny benefits or rescind your policy.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Signed at Anytown, ST (City) (State) ON 1-1-07 (Date)

Signature of Proposed Applicant 1: John Doe

Signed at Anytown, ST (City) (State) ON 1-1-07 (Date)

Signature of Proposed Applicant 2: Mary Doe

Section 7: Agent Statement

AGENT STATEMENT

Yes	No		
☐	☒	1.	**To the best of your knowledge, is the insurance applied for intended to replace any long term care, medical or health insurance in force with this or any other company?**
		2.	**List any other health insurance policies that you have sold to the Proposed Applicant(s):**

(a) Which of the policies listed above are still in force, if any?

(b) Which of the policies listed above sold in the past 5 years are no longer in force, if any?

☒	☐	3.	**Did you ask the Proposed Applicant(s) all the questions face to face and witness their signature(s)?**

If "No," provide details: _____

☒	☐	4.	**Did you deliver to the Proposed Applicant(s) the Outline of Coverage, the required Disclosures, the NAIC Shopper's Guide and the Notice of Privacy Practices?**

I certify that the answers to the questions provided by the Proposed Applicant(s) were fully and accurately recorded in the application, and that the questions in the Agent's Statement have been answered accurately. I have reviewed the current health insurance coverage of the Proposed Applicant(s) and find that the coverage of the type and amount applied for is appropriate for the needs of the Proposed Applicant(s). Further, if this is a replacement, I have reviewed the current health insurance coverage of the Proposed Applicant(s) and find that this replacement is appropriate for the needs of the Proposed Applicant(s).

John Q. Porter	1234	John Q. Porter	1-1-07
Licensed Agent's Name (please print)	Ident. Code	Licensed Agent's Signature	Date

(555) 555-1515	(555) 555-1414	5678
Agent's Phone	Agent's Fax	Agency Number

SERFF Tracking Number:	*LFCR-125715451*	*State:*	*Arkansas*
Filing Company:	*Massachusetts Mutual Life Insurance Company*	*State Tracking Number:*	*39506*
Company Tracking Number:	*MMN-PRT-AR*		
TOI:	*LTC03I Individual Long Term Care*	*Sub-TOI:*	*LTC03I.001 Qualified*
Product Name:	*SignatureCare*		
Project Name/Number:	*/*		

Rate Information

Rate data does NOT apply to filing.

SERFF Tracking Number:	*LFCR-125715451*	*State:*	*Arkansas*
Filing Company:	*Massachusetts Mutual Life Insurance Company*	*State Tracking Number:*	*39506*
Company Tracking Number:	*MMN-PRT-AR*		
TOI:	*LTC03I Individual Long Term Care*	*Sub-TOI:*	*LTC03I.001 Qualified*
Product Name:	*SignatureCare*		
Project Name/Number:	*/*		

Supporting Document Schedules

Satisfied -Name: Certification/Notice
Review Status: Approved-Closed 07/21/2008
Comments:
Attachment:
AR CERTIFICATION OF COMPLIANCE.pdf

Bypassed -Name: Application
Review Status: Approved-Closed 07/21/2008
Bypass Reason: New apps in Form Schedule
Comments:

Bypassed -Name: Health - Actuarial Justification
Review Status: Approved-Closed 07/21/2008
Bypass Reason: NA
Comments:

Bypassed -Name: Outline of Coverage
Review Status: Approved-Closed 07/21/2008
Bypass Reason: See Form Schedule
Comments:

Satisfied -Name: Cover Sheet
Review Status: Approved-Closed 07/21/2008
Comments:
Attachment:
AR-MM500 updates Cover Sheet.pdf

Satisfied -Name: Cover Letter
Review Status: Approved-Closed 07/21/2008
Comments:
Attachment:
AR MM Corected filing letter 07-21-08.pdf

CERTIFICATION OF COMPLIANCE

Insurer: Massachusetts Mutual Life Insurance Company

The company has reviewed the enclosed policy form(s) and certified that they comply with the provision of Regulation 19 as well as all applicable requirements of the Arkansas Department of Insurance.

Signature: Trudy Weigel

Name: Trudy Weigel

Title: Compliance Analyst

Date: July 1, 2008

FORM FILING COVER SHEET – AR

RATE STABILIZATION AND PARTNERSHIP FORMS

POLICY FORMS FILED FOR USE AS **QUALIFIED TAX STATUS:**

MME-CNFLP1	Contingent Benefit Upon Lapse Endorsement for Limited Pay Policy
MM-N-PRI-LP	Potential Rate Increase Disclosure Form
MME-RED1	Reduction of Benefits Endorsement
MM-N-LTC	Things You Should Know Before You Buy Long term Care Insurance

Partnership forms:

MMN-PRT-AR	Important Consumer Information Regarding the Arkansas Long-Term Care Insurance Partnership Program
MMD-PRT-AR	Important Notice Regarding Your Policy's Long-Term Care Insurance Partnership Status

Revised Forms:

MM500-OC-1-AR	Outline of Coverage revised and replacing MM500-OC-AR
MM501-OC-1-AR	Outline of Coverage revised and replacing MM501-OC-AR
MM500-A-1-AR	Application for Long Term Care revised and replacing MM500-A-AR
MM500-SA-1-1-AR	Application for Long Term Care revised and replacing MM500-SA-1-AR

MassMutual
FINANCIAL GROUP℠

July 21, 2008

Mr. Harris Shearer
Rate and Form Analyst
Arkansas Department of Insurance
VIA SERFF

RE: MASSACHUSETTS MUTUAL LIFE INSURANCE COMPANY – NAIC #65935
Long Term Care filing of Arkansas required rate stabilization and partnership forms For use with MM500-P-AR et al **Tax-Qualified Policy Forms**
Approved October 26, 2007

Dear Mr. Shearer:

The attached forms, as listed on the enclosed Form Filing Cover Sheet, are being filed for your review and approval as new forms and are intended for use with the above referenced previously approved individual long term care forms.

The following forms are being filed to comply with Arkansas adoption of revisions to Regulation 13 and the Arkansas Long Term Care Partnership Program Regulation 94.

Forms MME-CNFLP1, Contingent Benefit Upon Lapse Endorsement provides the required nonforfeiture if the applicant selects the 10-Pay or Paid-up at 65 premium payment option. Form MM-N-LTC, Things You Should Know Before You Buy Long Term Care Insurance will be given to each prospective applicant. MM-N-PRI-LP, Potential Rate Increase Disclosure Form, will be given to all prospective applicants and will advise them that the premiums may be increased in the future. Form MME-RED1, Lowering Premiums by Reducing Premiums Endorsement, allows the insured to reduce the premium on the policy by reducing the daily or maximum benefit amount.

The following forms are intended to be used in the Arkansas Long Term Care Partnership program as follows.

Form MMN-PRT-AR will be given to each prospective applicant applying for a partnership policy in Arkansas and Form MMD-PRT-AR will be attached to each policy that becomes a partnership policy as chosen in the Application and Outline. The certifications for the policies, MM500-P-AR and MM501-P-AR are attached to certify that the policies qualify as partnership policies.

Massachusetts Mutual Life Insurance Company
Long Term Care Administrative Office
21600 Oxnard Street, Suite 1500 • Mailing Address: Post Office Box 4243
Woodland Hills, CA 91365-4243
(888) 505-8952 • Fax (818) 887-4595

The following forms are revised to comply with the revised regulations and replace the original forms.

Application Forms MM500-A-1-AR, replacing MM500A-AR and MM500-SA-1-1-AR, replacing MM500-SA-1-AR and Outlines MM500-OC-1-AR and MM501-OC-1-AR are revised and replace MM500OC-GA and MM502-OC-GA to include the nonforfeiture benefits in the required rate stabilization regulation and include a line and box for each applicant to choose a partnership policy and to show the ages at which inflation protection is required.

The actuarial addendum for these forms and updates is included.

Sincerely

Trudy Weigel, LTCP
Compliance Analyst
(800) 366-5463 Ext. 2240
FAX # 818-867-2508
Email: trudy.weigel@lifecareassurance.com

SERFF Tracking Number:	*LFCR-125715451*	*State:*	*Arkansas*
Filing Company:	*Massachusetts Mutual Life Insurance Company*	*State Tracking Number:*	*39506*
Company Tracking Number:	*MMN-PRT-AR*		
TOI:	*LTC03I Individual Long Term Care*	*Sub-TOI:*	*LTC03I.001 Qualified*
Product Name:	*SignatureCare*		
Project Name/Number:	*/*		

Superseded Attachments

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Original Date:	Schedule	Document Name	Replaced Date	Attach Document
No original date	Supporting Document	Cover Letter	06/27/2008	AR MM rs and partnership filing letter.pdf

MassMutual
FINANCIAL GROUP℠

June 27, 2008

Mr. Harris Shearer
Rate and Form Analyst
Arkansas Department of Insurance
VIA SERFF

RE: MASSACHUSETTS MUTUAL LIFE INSURANCE COMPANY – NAIC #65935
Long Term Care filing of Arkansas required rate stabilization and partnership forms For use with MM500-P-AR et al **Tax-Qualified Policy Forms**
Approved October 26, 2007

Dear Mr. Shearer:

The attached forms, as listed on the enclosed Form Filing Cover Sheet, are being filed for your review and approval as new forms and are intended for use with the above referenced previously approved individual long term care forms.

The following forms are being filed to comply with Arkansas adoption of revisions to Regulation 13 and the Arkansas Long Term Care Partnership Program Regulation 94.

Forms MME-CNFLP1, Contingent Benefit Upon Lapse Endorsement provides the required nonforfeiture if the applicant selects the 10-Pay or Paid-up at 65 premium payment option. Form MM-N-LTC, Things You Should Know Before You Buy Long Term Care Insurance will be given to each prospective applicant. MM-N-PRI-LP, Potential Rate Increase Disclosure Form, will be given to all prospective applicants and will advise them that the premiums may be increased in the future. Form MME-RED1, Lowering Premiums by Reducing Premiums Endorsement, allows the insured to reduce the premium on the policy by reducing the daily or maximum benefit amount.

The following forms are intended to be used in the Georgia Long Term Care Partnership program as follows.

Form MMN-PRT-AR will be given to each prospective applicant applying for a partnership policy in Arkansas and Form MMD-PRT-AR will be attached to each policy that becomes a partnership policy as chosen in the Application and Outline. The certifications for the policies, MM500-P-AR and MM501-P-AR are attached to certify that the policies qualify as partnership policies.

Massachusetts Mutual Life Insurance Company
Long Term Care Administrative Office
21600 Oxnard Street, Suite 1500 • Mailing Address: Post Office Box 4243
Woodland Hills, CA 91365-4243
(888) 505-8952 • Fax (818) 887-4595

The following forms are revised to comply with the revised regulations and replace the original forms.

Application Forms MM500-A-1-AR, replacing MM500A-AR and MM500-SA-1-1-AR, replacing MM500-SA-1-AR and Outlines MM500-OC-1-AR and MM501-OC-1-AR are revised and replace MM500OC-GA and MM502-OC-GA to include the nonforfeiture benefits in the required rate stabilization regulation and include a line and box for each applicant to choose a partnership policy and to show the ages at which inflation protection is required.

The actuarial addendum for these forms and updates is included.

Sincerely

Trudy Weigel, LTCP
Compliance Analyst
(800) 366-5463 Ext. 2240
FAX # 818-867-2508
Email: trudy.weigel@lifecareassurance.com